Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

May 20, 2005

10:00 AM

Room 4203

Agenda

(Diane Van Maren)

Item	Department
0530	Health and Human Services Agency (Medicare Part D)
4280	Managed Risk Medical Insurance Board
4260	Department of Health Services
4440	Department of Mental Health

PLEASE NOTE:

(1) ALL previous actions taken by the Subcommittee remain, unless the Subcommittee otherwise modifies the proposal at the May Revision hearing.
(2) The "VOTE ONLY" CALENDAR for each department may include the modification or denial of proposals, as well as acceptance of proposals. This will be noted in the Agenda as applicable.
(3) Only those issues in today's agenda are before the Subcommittee.
(4) The Subcommittee will be completely closed out at our *Saturday, May 21st* hearing. All remaining issues and departments will be heard at that time.
(5) Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible.

I. ISSUES RECOMMENDED FOR "VOTE ONLY"

(Not in Department Item Order)

A. Item 4280--Managed Risk Medical Insurance Board *(Vote Only)*

1. Trailer Bill Language-- Continue Existing HFP Health Plan Enrollment Assistance

Issue: Through the Budget Act of 2001, trailer bill language was enacted that enabled health plans to partner with schools to conduct outreach and enrollment activities for the Healthy Families Program (HFP). A sunset was added to the language primarily because it was a new process. **As such, the existing statute sunsets as of January 1, 2006.**

Subcommittee Staff Recommendation: It **is recommended to amend Section 12693.325 of Insurance Code to delete the sunset as shown below**. No issues have been raised and the Administration has acknowledged that they have no concerns with this proposal.

12693.**325**.(a) (1) Notwithstanding any provision of this chapter, a participating health, dental, or vision plan that is licensed and in good standing as required by subdivision (b) of Section 12693.36 may provide application assistance directly to an applicant acting on behalf of an eligible person who telephones, writes, or contacts the plan in person at the plan's place of business, or at a community public awareness event that is open to all participating plans in the county, or at any other site approved by the board, and who requests application assistance.

(**2**) ~~**Until January 1, 2006,**~~ a participating health, dental, or vision plan may also provide application assistance directly to an applicant only under the following conditions:

(A) The assistance is provided upon referral from a government agency, school, or school district.

(B) The applicant has authorized the government agency, school, or school district to allow a health, dental, or vision plan to contact the applicant with additional information on enrolling in free or low-cost health care.

(C) The State Department of Health Services approves the applicant authorization form in consultation with the board.

(D) The plan may not actively solicit referrals and may not provide compensation for the referrals.

(E) If a family is already enrolled in a health plan, the plan that contacts the family cannot encourage the family to change health plans.

(F) The board amends its marketing guidelines to require that when a government agency, school, or school district requests assistance from a participating health, dental, or vision plan to provide application assistance, that all plans in the area shall be invited to participate.

(G) The plan abides by the board's marketing guidelines.

(b) A participating health, dental, or vision plan may provide application assistance to an applicant who is acting on behalf of an eligible or potentially eligible child in any of the following situations:

(1) The child is enrolled in a Medi-Cal managed care plan and the participating plan becomes aware that the child's eligibility status has or will change and that the child will no longer be eligible for Medi-Cal. In those instances, the plan shall inform the applicant of the differences in benefits and requirements between the Healthy Families Program and the Medi-Cal program.

(2) The child is enrolled in a Healthy Families Program managed care plan and the participating plan becomes aware that the child's eligibility status has changed or will change and that the child will no longer be eligible for the Healthy Families Program. When it appears a child may be eligible for Medi-Cal benefits, the plan shall inform the applicant of the differences in benefits and requirements between the Medi-Cal program and the Healthy Families Program.

(3) The participating plan provides employer-sponsored coverage through an employer and an employee of that employer who is the parent or legal guardian of the eligible or potentially eligible child.

(4) The child and his or her family are participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.
(5) The child's family, but not the child, is participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law, and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.
(c) A participating health, dental, or vision plan employee or other representative that provides application assistance shall complete a certified application assistant training class approved by the State Department of Health Services in consultation with the board. The employee or other representative shall in all cases inform an applicant verbally of his or her relationship with the participating health plan. In the case of an in-person contact, the employee or other representative shall provide in writing to the applicant the nature of his or her relationship with the participating health plan and obtain written acknowledgment from the applicant that the information was provided.
(d) A participating health, dental, or vision plan that provides application assistance may not do any of the following:
(1) Directly, indirectly, or through its agents, conduct door-to-door marketing or telephone solicitation.
(2) Directly, indirectly, or through its agents, select a health plan or provider for a potential applicant. Instead, the plan shall inform a potential applicant of the choice of plans available within the applicant's county of residence and specifically name those plans and provide the most recent version of the program handbook.
(3) Directly, indirectly, or through its agents, conduct mail or in-person solicitation of applicants for enrollment, except as specified in subdivision (b), using materials approved by the board.
(e) A participating health, dental, or vision plan that provides application assistance pursuant to this section is not eligible for an application assistance fee otherwise available pursuant to Section 12693.32, and may not sponsor a person eligible for the program by paying his or her family contribution amounts or copayments, and may not offer applicants any inducements to enroll, including, but not limited to, gifts or monetary payments.
(f) A participating health, dental, or vision plan may assist applicants acting on behalf of subscribers who are enrolled with the participating plan in completing the program's annual eligibility review package in order to allow those applicants to retain health care coverage.
(g) Each participating health, dental, or vision plan shall submit to the board a plan for application assistance. All scripts and materials to be used during application assistance sessions shall be approved by the board and the State Department of Health Services.
(h) Each participating health, dental, or vision plan shall provide each applicant with the toll-free telephone number for the Healthy Families Program.
(i) When deemed appropriate by the board, the board may refer a participating health, dental, or vision plan to the Department of Managed Health Care or the State Department of Health Services, as applicable, for the review or investigation of its application assistance practices.
(j) The board shall evaluate the impact of the changes required by this section and shall provide a biennial report to the Legislature on or before March 1 of every other year. To prepare these reports, the State Department of Health Services, in cooperation with the board, shall code all the application packets used by a managed care plan to record the number of applications received that originated from managed care plans. The number of applications received that originated from managed care plans shall also be reported on the board's Web site. In addition, the board shall periodically survey those families assisted by plans to determine if the plans are meeting the requirements of this section, and if families are being given ample information about the choice of health, dental, or vision plans available to them.
(k) Nothing in this section shall be seen as mitigating a participating health, dental, or vision plan's responsibility to comply with all federal and state laws, including, but not limited to, Section 1320a-7b of Title 42 of the United States Code.
~~**(l) Paragraph (2) of subdivision (a) shall become inoperative on January 1, 2006.**~~

2. Healthy Families—Changing Single Point of Entry—Conform to Prior Action

Issue: In the April 4th Subcommittee hearing, **the Subcommittee *rejected* the Administration's proposal to *change* the existing Single Point of Entry process** by, among other things, using a contractor to conduct certain eligibility determination processing in lieu of using County Welfare Department personnel. **As such, the appropriation for the DHS related items was amended at that time.**

However, the Administration had an error in their January budget for the MRMIB's budget related to their proposal. Specifically, they had noted that the HFP budget did not reflect an increase of $1.9 million (total funds) that would be needed for them to implement their proposed change. Since the dollars were not in the Administration's budget at that time, no action on them could be taken.

The May Revision now contains an appropriation of $1.9 million (total funds). Since the HFP is presented to the Subcommittee as an estimate package, it is recommend to take action to reject this funding to conform with the Subcommittee's prior action so that it is absolutely clear on what needs to be adjusted.

Subcommittee Staff Recommendation: It is recommended **to reject the $1.9 million (total funds) in the HFP budget for their proposal to change the Single Point of Entry process in order to conform to a prior Subcommittee action.**

3. County Health Initiative Matching Fund (CHIM) Program--Technical

Issue: The May Revision proposes to adjust the January budget for CHIM by $1 million ($350,000 County Health Initiative Matching Fund and $650,000 federal S-CHIP Funds) for total expenditures of $4.663 million ($1.632 million County Health Initiative Matching Funds) for 2005-06.

The MRMIB states that the May Revision reflects updated funding estimates submitted by the four pilot counties (Alameda, San Francisco, San Mateo, and Santa Clara), as well as the projected expenditures for one of the Phase II counties (Santa Cruz).

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised. This program was discussed in our April 25 hearing.

Background—County Health Initiative Matching Fund (CHIM) Program: AB 495, Statutes of 2001, allow county governments and public entities to provide local matching funds to draw down federal S-CHIP funds for their Healthy Kids Programs (i.e., children 250 to 300 percent of poverty who are citizens). The State Plan Amendment approved by the federal CMS provided for four pilot counties (i.e., Alameda, San Francisco, San Mateo, and Santa Clara) with a phase-in of additional counties (i.e., Santa Cruz and Tulare) in 2005-06.

B. Item 4440 — Department of Mental Health *(Vote Only)*

1. Healthy Families Program Adjustments—*Supplemental Mental Health Services*

Governor's May Revision: The May Revision **proposes a *net* reduction of $2.5 million (Reimbursements from the MRMIB) to primarily reflect technical caseload adjustments to the HFP supplemental mental health services**. This adjustment is due to updated paid claims data and county administration adjustments. Total program expenditures are now estimated to be $14.9 million (total funds—federal reimbursement from the MRMIB and county realignment funds).

Background: The Healthy Families Program provides health care coverage and dental and vision services to children between the ages of birth to 19 years with family incomes at or below 250 percent of poverty (with income deductions) who are not eligible for no-cost Medi-Cal. Monthly premiums, based on family income and size, must be paid to continue enrollment in the program. California receives an annual federal allotment of federal Title XXI funds (Social Security Act) for the program for which the state must provide a 34 percent General Fund match, except for supplement mental health services in which County realignment funds are used as the match. With respect to legal immigrant children, the state provides 100% General Fund financing.

The enabling Healthy Families Program statute linked the insurance plan benefits with a supplemental program to refer children who have been diagnosed as being seriously emotionally disturbed (SED). The supplemental services provided to Healthy Families children who are SED can be billed by County Mental Health Departments to the state for a federal Title XXI match. Counties pay the non-federal share from their County Realignment funds (Mental Health Subaccount) to the extent resources are available.

Subcommittee Staff Comment and Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

2. Conforming Action on Early Mental Health Program (Prop 98)

Issue and Subcommittee Staff Recommendation: The Governor's January budget proposed to reduce this program by $5 million (Proposition 98 General Fund) leaving only $5 million available for grants to schools to provide assistance to children in K to Third Grade.

In their May Revision hearing, the Senate Subcommittee #1 on Education designated an augmentation of $5 million (Proposition 98 Funds) for this program. Therefore, it is recommended for to increase Item 4440-102-0001 (Department of Mental Health) by this $5 million amount and eliminate the Governor's reduction. This will enable a new round of grants to be started and will continue the program.

Background—What is the Program: Under the Early Mental Health Initiative, the state awards grants (for up to three-years) to Local Education Agencies (LEAs) to implement early mental health intervention and prevention programs for students in Kindergarten through Third Grade. Schools that receive grants must also provide at least a 50 percent match to the funding provided by the DMH. Schools use the funds to employ child aides who work with students to enhance the student's social and emotional development.

Students in the program are generally experiencing mild to moderate school adjustment difficulties. Students must have parental permission to participate in the program. In addition, all Early Mental Health Initiative programs are required to contract with a local mental health agency for referral of students whose needs exceed the service level provided in this program.

The Early Mental Health Initiative is an effective school-based program. **It serves children experiencing school adjustment issues who are *not* otherwise eligible for special education assistance or county mental health services because the student's condition is usually not severe enough to meet the eligibility criteria in these other programs (such as the Children's System of Care Program or EPSDT services).**

3. Lease Revenue Bond Payment Adjustments—DMH Portion

Issue: The May Revision proposes to make an adjustment to the DMH budget for the purpose of allocating the set-aside contained in Budget Control Section 4.30 related to Lease Revenue Debt Service which was in the January budget. Specifically, the DMH budget is proposed to receive $27.034 million, including $88,000 in Reimbursements, for this purpose.

This is a technical adjustment to the budget to schedule these funds as needed in departments. The DMH amount reflects payment for construction of Coalinga State Hospital and some capital improvement projects at other hospitals.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision as proposed.**

4. Energy Efficiency Bond Program Repayment

Issue: The May Revision proposes a reduction of $475,000 (General Fund) in the State Hospital Item to reflect utility savings generated from energy efficiency projects at Metropolitan State Hospital and repayment to the General Fund for these projects.

AB 156, Statutes of 204 provided $3.7 million (General Fund) to repay loans from the Pooled Money Investment Account that provided interim funding for these projects. Repayment to the General Fund, plus five percent interest, will occur over a ten-year period through the utility savings generated by the projects.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision as proposed.** No issues have been raised.

5. Six-Month Extension for Emergency Mental Health Managed Care Regulations

Issue: As has been discussed in past years, the DMH is behind in completing their "regular" regulations for the Mental Health Managed Care Program. **Therefore, the May Revision is seeking a 6-month extension of emergency regulation authority, from January 1, 2005 to June 30, 2006.**

Subcommittee Staff Recommendation: It **is recommended to adopt the May Revision trailer bill language which provides the DMH with a six-month extension of emergency regulation authority until they complete their "regular" regulations.**

It should be noted that the DMH has been making progress on completing this regulation package. However, completion of the package is also contingent upon the completion of work by other entities, such as the Department of Health Services (serving in the "sole Medicaid state agency" role.). The DMH has made a commitment to have this as a priority to complete and maintains that the June 30, 2006 deadline will indeed be meet.

6. Adjustments for the San Mateo Field Test—Medicare Part D

Issue: The May Revision proposes a decrease of $672,000 (General Fund) to the DMH to adjust the funding levels provided for pharmacy expenditures in the San Mateo Field Test Project. This reduction is the result of implementing the federal Medicare Part D drug benefit as of January 1, 2006. With implementation of the federal Medicare Part D drug benefit, dual eligibles will lose Medi-Cal coverage for some medications currently covered by the San Mateo Pharmacy field test.

The DMH is proposing to reduce state funding for San Mateo pharmacy services by 10 percent. This reflects a half-year (January 1, 2006 to June 30, 2006) amount. If San Mateo wants to provide alternative coverage for individuals that may need assistance, they can choose to do that using County Realignment funds.

Subcommittee Staff Recommendation: It **is recommended to adopt the May Revision as proposed.** No issues have been raised.

Additional Background—What is the San Mateo Field Test Project? The San Mateo County Mental Health Department has been operating as the mental health plan under a federal Waiver agreement and state statute as a "field test" project since 1995. San Mateo is the only county that has responsibility for the management of some financial risk through a case rate system and the management of pharmacy and related laboratory services, in addition to being responsible for psychiatric inpatient hospital services and outpatient specialty mental health services.

The field test is intended to test managed care concepts which may be used as the state progresses towards the complete consolidation of specialty mental health services and eventually, a capitated or other full-risk model. As the San Mateo Field Test Project has matured and evolved, additional components have been added and adjusted.

7. Forensic Conditional Release Program (CONREP) Funding Adjustments

Issue: The May Revision proposes total expenditures of $15.4 million (General Fund) for a net decrease of $436,000 (General Fund) for CONREP. This reduction is primarily due to a reduction in caseload and is purely technical.

According to the DMH, this estimate will provide for outpatient treatment and supervision for a caseload of 730 patients (average cost of $21,091 per patient).

The balance of the funding supports contracts for (1) toxicology services with ancillary service providers, (2) pharmacy services for patients on Clozaril medication, (3) an answering service to meet statutory requirements, (4) statutorily required hearings, and (5) assessment services.

The budget consists of three key components, including (1) hospital liaison visits, (2) patient services, (3) funding for SVPs. The hospital liaison visits are done to assess outpatient readiness of State Hospital patients who are either Not Guilty by Reason of Insanity (NGI) or are a Mentally Disordered Offender (MDO).

In August 2003, the first SVP was placed into CONREP. The program as developed by the DMH includes sex offender treatment, dynamic risk assessments, psychiatric medications, and various monitoring tools (such as polygraphs, substance abuse screenings, and GPS monitoring), as well as supervision. The DMH is responsible for program, medical and living costs for the patient. The DMH contracts with Liberty Healthcare for SVP CONREP services in all 58 counties.

Background—Description of CONREP: Existing statute provides for the Conditional Release Program (CONREP). Specifically, it mandates for the DMH to be responsible for the community treatment and supervision of judicially committed patients, including Not Guilty by Reason of Insanity (NGI), Mentally Disordered Sex Offenders (MDOs), and Sexually Violent Predators.

CONREP, in operation since 1986, provides outpatient services to patients in the community and hospital liaison visits to patients continuing their inpatient treatment at State Hospitals who may eventually be admitted into CONREP.

CONREP services are provided throughout the state and are either county-operated *or* private/non-profit operated under contract to the DMH. The goal of CONREP is to ensure greater public protection in California communities via a system of mental health assessment, treatment, and supervision to persons placed on outpatient status.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision as proposed.**

C. Item 4260 — Department of Health Services *(Vote Only)*

1. Child Health Disability Prevention (CHDP) Program

Issue: The **May Revision proposes total expenditures of $2.6** ($2.5 million General Fund and $102,000 Childhood Lead Poisoning Prevention Funds) for the program. This reflects a *net* increase of $727,000 (increase of $925,000 General Fund). The program will provide about 48,600 health screens for children. This reflects an increase of 8,800 screens over the January proposal. **The May Revision also contains an increase of $4,000 to add the fasting blood sugar and cholesterol screening as part of the CHDP health assessments when indicated.**

Subcommittee Staff Recommendation: It is recommended to **adopt the May Revision** as proposed.

Overall Background: The Child Health Disability Prevention (CHDP) Program provides pediatric prevention health care services to **(1)** infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and **(2)** children and adolescents who are eligible for Medi-Cal services up to age 21 (Early Periodic Screening Diagnosis and Treatment—EPSDT).

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health examination certificate or an equivalent examination to enroll in school.

The benefit package provided under the *CHDP-only* program is limited to providing a physical examination, nutritional assessment, vision and dental assessments, hearing assessment, laboratory tests and immunizations. Local health jurisdictions work directly with CHDP providers (private and public) to conduct planning, education and outreach activities, as well as to monitor client referrals and ensure treatment follow-up. With respect to funding, services for

2. Genetically Handicapped Persons Program (GHPP)—Cash/Accrual Change and Caseload Adjustment

Issue: The May Revision proposes a decrease of $22 million (General Fund) which is primarily due to the Administration's proposal to shift the GHPP from an accrual to cash accounting system, as was done with the Medi-Cal Program. Total program expenditures are estimated to be $33.5 million (General Fund) for the GHPP.

The accounting shift saves a total of $15.6 million General Fund in 2005-06. In addition, there is a minor caseload reduction and related technical adjustments. No policy changes are proposed other than the accounting shift.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

Overall Background: The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially ineligible for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fee and treatment costs based on a sliding fee scale for family size and income.

3. California Children's Services (CCS) Program

Issue: The Governor's May Revision proposes a *net* increase of $3.5 million (decrease of $1.9 million General Fund, increase of $5.4 million federal S-CHIP Title XXI funds, and a decrease of $55,000 in enrollment fees for total expenditures of $180.8 million (total funds).

This May Revision reflects minor caseload and technical adjustments. No policy changes are proposed. The increase in federal funds is primarily due to the availability of S-CHIP funds for AIM-born infants who need CCS services. This reflects existing state policy and statute.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

Overall Background on CCS: The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence. The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

The CCS is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program), **(2)** CCS and Medi-Cal eligible, and **(3)** CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as county funds.

4. Fiscal Appropriations for Funding of Nurse-to-Patient Ratio

Issue & Prior Subcommittee Action: In the Subcommittee's April 4th hearing, the Subcommittee adopted place holder language to address concerns regarding the Administration's review for compliance regarding the nurse-to-patient ratio. In addition, concerns were expressed regarding "truth in budgeting" with respect to how the Medi-Cal Program Estimate package presented the issue. **It is in response to this discussion that the following Subcommittee staff recommendation is proposed**.

Subcommittee Staff Recommendation: It is recommended to **adopt** the following pieces of trailer bill language and Budget Bill Language as proposed by Subcommittee staff:

(1) Uncodified Trailer Bill Language for Compliance Comparison

The Department of Health Services shall provide the Legislature by no later than July 1, 2006 with a comprehensive review of nurse staffing levels that is a statistically valid sample of hospitals that are urban and rural, public and private, proprietary and non-profit, geographically-balanced, and small and large. At a minimum, this analysis shall include a comparison to the 2001 baseline staffing study, including the extent to which hospitals have increased registered nurse and licensed vocational nurse staffing.

(2) Uncodified Trailer Bill Language for CMAC Information

On an annual basis the Department of Health Services and the California Medical Assistance Commission shall provide fiscal information to the Joint Legislative Audit Committee and the Joint Legislative Budget Committee on the funds provided to the contract hospitals participating in the Medi-Cal Program, and the health plans participating in the Medi-Cal Managed Care Program for implementation of the nurse-to-patient ratios.

(3) Budget Bill Language for "Truth in Budgeting" (Item 4260-101-0001)

It is the intent of the Legislature that funding appropriated to the Department of Health Services for the Medi-Cal Program shall be expended for purposes that are consistent with the assumptions and estimates as defined in Section 14100.5.

Any change in the assumptions and estimates for the Medi-Cal Program, as defined in Section 14100.5, that results in an expenditure that is inconsistent with the purposes for which the Legislature appropriated the funding shall not be authorized by the Director of the Department of Finance any sooner

5. Expenditure of Federal Bioterrorism Funds—State Support & Local Funds

Issue: ***First,*** the Governor's January budget requested to extend 94.8 positions for two-years (to June 30, 2007) to continue existing efforts relating to bioterrorism preparedness and response as directed under federal grant agreements with the federal Centers for Disease Control and Prevention (CDC) and the federal Health Resources and Services Administration (HRSA). The DHS requests an appropriation of $8.2 million (federal funds) to continue these 94.8 positions in 2005-06.

Presently the DHS has a total of 104.8 positions of which 10 are permanent and 94.8 are limited-term and expire as of June 30, 2005. Of the 94.8 limited-term positions, 76 positions are associated with functions related to the CDC grant and 18.8 positions pertain to the HRSA grant. The remaining 10 permanent positions all pertain to the CDC grant.

The tables below summarize the request to extend (two-years) the 94.8 positions. As noted in the background discussion below, the existing CDC grant has seven "focus" areas and the HRSA grant has four "benchmark" measurements. The requested positions are therefore listed by these areas.

I. CDC Grant and Focus (76 positions)	Positions		Positions
A. Preparedness Planning & Readiness		**D. Laboratory Capacity--Chemical**	
Health Prog Mgr II/III	2	Research Scientist Supervisor IV	1
Environmental Sci IV	1	Research Scientist II/III	2
Medical Officer III	1	Staff Services Analyst	1
Pharmaceutical Consultant	1		7 total
Health Prog Specialist	1	**E. Health Alert Network**	
Staff Services Manager	1	Sr Information System Supvsr	1
Sr Accounting Officer	1	Information System Analysts	1
Associate Gov Analyst	4	Associate Info System Analysts	2
Office Technician	1		**4 total**
	15 total		
B. Surveillance & Epidemiology		**F. Health Risks & Health Info**	
Medical Officers II/III	3	Health Education Consultant III	1
Research Scientists II/III/ IV	12	Research Analyst II	1
Sr Information Systems Analysts	3	Staff Services Analyst	1
Associate Gov Analyst	2		**3 total**
Sr Sanitary Engineer	2		
Office Technician	1		
	23 total		
C. Laboratory Capacity--Biologic		**G. Education & Training**	
Microbiologist Specialists	3	Medical Officer III	2
Microbiologist I/II	11	Nurse Consultant III	1
Research Scientist IV	2	Associate Systems Analyst	1
Associate Gov Analyst	1	Associate Gov Analyst	1
Office Technician	1	Office Technician	1
	18 total		**6 total**

HRSA Grant Positions (18.8 total)	Positions		Positions
Priority Area 1—Program Direction		**Priority Area 3—Laboratory Connectivity**	
Staff Services Manager I	1	Health Program Specialist I	1
Health Program Specialist I	1.5		**1 total**
Research Analyst II	0.5	**Priority Area 4—Laboratory Data Standard**	
Associate Governmental Prog Analyst	2	Medical Officer III	2
Office Technician	1	Research Scientist III/IV	3
	6 total	Associate Governmental Prog	1
Priority Area 2—Regional Surge Capacity			**6 total**
Nurse Consultant II	1		
Associate Info Systems Analyst	1		
Health Program Specialist II	1.7		
Word Processing Technician	1		
Office Technician	1		
	5.7 total		

Second, the five-year bioterrorism grant provided by the Centers for Disease Control (CDC) used to fund 86 of the positions (i.e., 76 limited-term and 10 permanent) will expire on August 30, 2005 and a new multi-year grant will begin. The CDC has yet to finalize specifics on the requirements for the new federal grant funding cycle and it is unclear at this time when this guidance will be forthcoming to the states. As such, it is unclear as to whether all of the requested positions can be funded under the new cycle or whether the CDC will be changing its focus for states.

The table below summarizes the total funds received by the DHS to-date for both the CDC and HRSA grants.

Summary of DHS Funding (as of 12/30/04)	CDC Grant	HRSA Grant	TOTALS
1. Total Federal Funds Received (From 8/31/99 to 8/30/05)	**$195,152,000**	**$87,511,000**	**$282,663,000**
2. State Operations Total Amount	**$60,894,000**	**$35,017,000**	**$95,911,000**
Expenditures	$34,012,000	$12,550,000	$46,562,000
Encumbrances	$12,590,000	$8,403,000	$20,993,000
Remaining Balance	($14,292,000) 23.5 %	($14,064,000) 40.2%	($28,356,000) 29.6%
3. Local Assistance Total Amount	**$134,258,000**	**$52,494,000**	**$186,752,000**
Expenditures	$83,451,000	$3,272,000	$86,723,000
Encumbrances	$47,405,000	$42,532,000	$89,937,000
Remaining Balance	($3,402,000) 2.5%	($6,690,000) 12.7%	($10,092,000) 5.4%
4. Total Summary for the Grants	**$195,152,000**	**$87,511,000**	**$282,663,000**
Expenditures	$117,463,000	$15,822,000	$133,285,000
Encumbrances	$59,995,000	$50,935,000	$110,930,000
Remaining Balance (Not obligated)	($17,694,000) 9.1%	($20,754,000) 23.7%	($38,448,000) 13.6%

Third, the Legislative Analyst's Office (LAO) contends that the Administration overall, including the DHS, Office of Homeland Security (OHS), and others, lacks a unified strategic approach to homeland security, and that only 31 percent of the state's overall

Existing State Statute: Existing statute provides a framework for the DHS to contract with, and allocate to, Local Health Jurisdictions for expenditure of bioterrorism funds (local assistance). Among other things, existing statute (1) requires the DHS to develop a plan with representatives of local governments for submittal to the federal government for receipt of the grant funds, (2) requires the DHS to develop a streamlined process for continuation of bioterrorism preparedness funding that will address any new federal requirements and will assure continuity of local plan activities, (3) enables the DHS to contract with public or private entities to meet the federally-approved bioterrorism plan and these contracts shall be exempt from the State Contract Act, and (4) enables the DHS to allocate these funds to Local Health Jurisdictions generally on a per capita basis.

Prior Subcommittee Hearing: In the March 14th hearing, the Subcommittee **(1)** adopted Budget Bill Language to require the DHS to provide the Bureau of State Audits with information for auditing purposes, **(2)** adopted placeholder trailer bill language to require the DHS to provide the Legislature with an accounting of their expenditures (proposed language is contained below), and **(3)** left the issue of the positions opening pending receipt of further guidance from the federal CDC regarding this year's grant cycle.

Senate Subcommittee #5 Action: In addition, **Senate Subcommittee #5 adopted language**, similar to language suggested by the LAO, regarding the Office of Homeland Security and the Department of Health Services. This language is as follows:

> ***Proposed Budget Bill Language for development of a statewide strategic plan:***
> The Office of Homeland Security, in collaboration with the Department of Health Services, shall report to the Chairperson of the Joint Legislative Budget Committee, and the chairperson of the budget and policy committees of each house of the Legislature on or before January 10, 2006, a statewide strategic plan for the use of federal homeland security and bioterrorism funds by all departments and local jurisdictions. The plan shall include the state's goals and objectives for improving the state's level of preparedness for a terrorism event, which 1) is based on an assessment of the state's level of preparedness and 2) reflects a coordination of preparedness activities at the state and local level. It is not the intent of the Legislature to require the Office of Homeland Security or the Department of Health Services to disclose or include sensitive or classified information in the strategic plan.
>
> ***Proposed Trailer Bill Language for an annual expenditure report:***
> **Section x.** The Office of Homeland Security, in collaboration with the Department of Health Services, shall annually report to the Chairperson of the Joint Legislative Budget Committee, and the chairperson of the budget committees of each house of the Legislature on or before January 10, its expenditures of federal homeland security and bioterrorism funds. This report shall include: 1) descriptions of the grant expenditures and coordination activities at the state and local level that have occurred over the past year; 2) how those activities met the state's strategic goals and objectives; 3) the funding amounts

awarded to local jurisdictions and specific departments; 4) the funding levels by grant and grant year that have been expended, encumbered, and unencumbered; 5) any challenges that the departments or local jurisdictions encountered that hindered the expenditure of these funds; and 6) the areas of focus for the upcoming year. It is not the intent of the Legislature to require the Office of Homeland Security or the Department of Health Services to disclose or include sensitive or classified information in the strategic plan.

Assembly Subcommittee #1 Action: In addition, the Assembly Subcommittee #1 adopted trailer bill language to require audits of the local expenditures every three years. This trailer bill language is as follows:

> "It is the intent of the Legislature that the department shall audit the cost reports every three years commencing January 2007 to determine compliance with federal requirements and consistency with local health jurisdiction budgets, contingent upon the availability of federal funds for this activity and contingent upon the continuation of federal funds for bioterrorism preparedness.

Subcommittee Staff Recommendation: It is recommended to **(1)** retain the Budget Bill Language adopted in the March 14th hearing regarding the Bureau of State Audits,**(2)** rescind placeholder trailer bill language from the prior Subcommittee action for expenditure reporting since the Subcommittee #5 action provides similar language that has already been negotiated, **(3)** conform to the Senate Subcommittee #5 action by adopting the same Budget Bill Language for Item 4260-111-0001 (DHS item) and the same trailer bill language, **(4)** approve the Administration's request to continue the 94.8 positions using federal funds, **(5)** adopt the Assembly's trailer bill language regarding an audit every three years as shown above, and **(6)** adopt the following trailer bill language to require the coordination of DHS bioterrorism activities with the CA Office of Border Health (as shown below).

In addition, it is also recommended to add trailer bill language as follows in order to ensure that bioterrorism activities are coordinated with the California Office of Binational Border Health. This proposed language is as follows:

> "The Department of Health Services shall coordinate their federal bioterrorism activities as applicable with the California Office of Binational Border Health, as the single point of coordination on border health activities. These activities shall include at a minimum the following: (1) surveillance for the spread of infectious disease, (2) monitoring for environmental health safety issues related to food safety and air and water quality, and (3) responding to any potential bioterrorism threat."

These proposed actions would (1) provide the Administration with their requested funding and positions; (2) conform to both the Senate and Assembly actions as noted above; and (3) reintegrate the importance of coordination of bioterrorism activities along the border between California and Mexico.

6. AIDS Drug Assistance Program (ADAP)—May Revision Adjustment

Issue: The Governor's May Revision proposes total expenditures of $268.3 million ($91.1 million General Fund, $100.9 million federal Ryan White Care Act Funds, and $76.3 million in ADAP Drug Rebates) for ADAP.

This reflects a *net* increase of $4.7 million (increase of $4.7 million ADAP Drug Rebates, a decrease of $79,000 General Fund and an increase of $79,000 federal Ryan White Care Act Funds). This proposed adjustment is the result of (1) steadily increasing drug prices, and (2) increased access to those drugs by ADAP clients. This estimate is based on actual data expenditures through March 2005.

It should be noted that ADAP affects demand for Medi-Cal services. Without ADAP assistance to obtain HIV/AIDS drugs, infected individuals would be forced to (1) postpone treatment until disabled and Medi-Cal eligible, or (2) spend down their assets to quality, increasing expenditures under Medi-Cal. Fifty percent of Medi-Cal costs are borne by the state as compared to about 28 percent of ADAP costs.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. It should be noted that though the Office of AIDS has done well in securing drug rebate funds, the state should not become too reliant on this resource as a stable funding agent. Some of the rebate contracts will be expiring within a few months. As such, it is recommended to adopt the May Revision which maintains a reasonable funding mix.

7. Administration's Proposed Trailer Bill Legislation—CalWORKS & Medi-Cal

Issues: The Governor's May Revision proposes to reduce CalWORKS by changing the "maximum aid payments" (MAP) for CalWORKS recipients commencing as of July 1, 2005. Any change to this calculation would affect the Section 1931 (b) families program income eligibility threshold in the Medi-Cal Program.

As such, the Administration's proposes trailer bill language to maintain the existing Medi-Cal income standard for Section 1931 (b) families at its current level (i.e., not less than the income standard that was in effect on January 1, 2004.

In addition, the May Revision contains an increase of $1.560 million ($780,000 General Fund) for County Administration processing in order to shift CalWORKs individuals in Medi-Cal from CalWORKS-linked to "Medi-Cal" only.

Subcommittee Recommendation: It is recommended to **reject** the Administration's language and funding request because it is not necessary (i.e., conforming action). The Subcommittee rejected the CalWORKS MAP reduction and as such, does not need to make any changes to the Medi-Cal Program. **Therefore, a reduction of $1.560 million ($780,000 General Fund) is also recommended.**

8. Botulism Treatment and Prevention Program and "BabyBIG"

Issue: The Assembly Subcommittee adopted placeholder trailer bill language to reimburse hospitals for BabyBIG which is used to treat Infant Botulism poisoning.

The proposed language is as follows. In discussions with the DOF and DHS, no concerns were raised regarding the language. As such, it is recommended to conform to the Assembly language.

Add Section 14085.6 (g) (4) to Welfare and Institutions Code as follows:

> Be able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent, yet high-cost services such as anti-AB human antitoxin treatment for infant botulism (HBIG - human botulinum immune globulin, commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

The above language directs the California Medical Assistance Commission to specifically consider the costs of BabyBIG in its reimbursement rate contract negotiation with hospitals.

Each dose of BabyBIG costs $45,300 to purchase. California averages about forty cases per year. Currently there is no specific reimbursement mechanism to reimburse the hospitals that provide the medical care to young children stricken with the potentially lethal disease. The proposed language would remedy this.

Subcommittee Staff Recommendation: It is recommended to **conform** to the Assembly and adopt the trailer bill language.

Background on the Program: The purpose of the Infant Botulism Treatment and Prevention Program is to provide and improve the treatment of infant botulism, and to prevent infant botulism and related diseases.

The program became permanently effective in May 1997 when its multi-year clinical trial of the Orphan Drug human Botulism Immune Globulin (BIG) demonstrated its apparent safety and efficacy as the first specific treatment for infant botulism. BIG was officially licensed by the U.S. Food and Drug Administration on October 23, 2003 for the treatment of infant botulism types A and B under the proprietary name of BabyBIG.

State statute established the program (H&SC Sect. 123700-123709) as a fee-supported, special fund activity that is required to (1) produce and distribute BabyBIG® statewide and nationwide, (2) provide diagnostic and consultative medical services for infant botulism, (3) investigate all cases of infant botulism in California, (4) develop and implement prevention and control measures for infant botulism, and (5) carry out applied research into improving the prevention and treatment of infant botulism and related illnesses.

BabyBIG® represents the "standard-of-care" for all patients hospitalized with infant botulism. The high national profile of the program is also a consequence of its interactions with the U.S. Food and Drug Administration (FDA), the U.S. Centers for Disease Control and Prevention (CDC), the Massachusetts Public Health Biologic Laboratories, all California local Health Departments and approximately 200 major university, children's, and community hospitals statewide and nationwide.

Through the development phase the program was funded by loans from the State's General Fund. The loan from the General Fund is approximately $3.5 million and is to be repaid from the fees charged providers. At the current rate of utilization it will take three to four years to repay the loan.

9. California Rx Program Funding—January Budget & May Revision

Issue: The Governor's January budget proposed an increase of $3.9 million (General Fund) to fund 18.5 positions to establish a state pharmacy assistance program for certain low-income individuals who do not have a public or private prescription drug benefit.

In addition, the May Revision proposes an increase of $7.8 million (General Fund) for **total proposed expenditures of $11.7 million** (General Fund). Of the total $11.7 million, (1) $5.7 million was for various administrative support functions, including the 18.5 positions and (2) $6.4 million was for local assistance.

Policy legislation to implement the proposed Cal Rx Program has stalled in the Senate Health Committee. Further, in her Perspectives and Issues document (pages 244 to 261), the Legislative Analyst's Office raised considerable policy and fiscal issues with the Governor's January proposal. There are also several potential ballot initiatives regarding implementation of subsidized pharmacy programs. In addition, as discussed further below, the federal Medicare Part D Program which is pending implementation as of January 1, 2006, potentially complicates how a Cal Rx Program would operate.

Subcommittee Staff Recommendation: It is recommend to **reject** the $3.9 million (General Fund) in the budget **and** the $7.8 million (General Fund) proposed in the May Revision.

In its present form, the Cal Rx Program needs considerable work to proceed through both houses of the Legislature. Therefore the timelines of the budget process are ill suited for development of this new program.

10. Consumer Price Index Adjustment--Nuclear Planning Assessment Special Account

Issue: The May Revision proposes an increase of $16,000 (Nuclear Planning Assessment Special Account) as required by Section 8610.5 of the Government Code which provides for a consumer price index adjustment. These funds are used to support the existing Nuclear Power Preparedness Program.

Legislation mandating the Nuclear Power Preparedness Program has been continuous since 1979, enacted as Government Code Section 8610.5, the Radiation Protection Act. The program is funded by the utilities through a special assessment fund managed through the State Controller.

While State OES has absolute coordination authority during emergency response, **the Department of Health Services (DHS) is assigned the technical lead responsibility during ingestion pathway and recovery phases of an emergency.** The goal during ingestion pathway response is preventing contaminated water, food and food animals from reaching the consumer. The goal during recovery is restoring areas to pre-accident conditions.

Background: In California, there are two operating nuclear power plant sites: Diablo Canyon in San Luis Obispo County has two active units and San Onofre Nuclear Generating Station (SONGS) in San Diego County has two active units. A third unit at SONGS is in a "safe storage" mode (fuel has been removed and stored). The operating life of the active units is expected to extend well into the 21st century.

Under state law, counties have the authority and responsibility to protect the lives and property of their citizens. The state supports their emergency response activities involved in nuclear power plant planning.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

11. Genetic Disease Testing Program Fund—Repay General Fund Loan

Issues: The May Revision proposes to add a provision to the Budget Bill to require the Genetic Disease Testing Fund **to fully repay outstanding General Fund loans that were provided in the Budget Acts of 2002 and 2003 by June 30, 2006** (i.e., add Item 4260-402).

These two Budget Acts authorized a total of $10.3 million in General Fund loans to the Genetic Disease Testing Fund to be paid back by June 30, 2008 and June 30, 2009, respectively. As of July 1, 2005, outstanding General Fund loans to the Genetic Disease Testing Fund will total $7.2 million. **The DOF states that due to favorable revenue collections and increased collection rates, the Genetic Disease Testing Fund will have sufficient resources to repay the loans on an accelerated schedule.**

The proposed language for this purpose is as follows:

"4260-402—Nothwithstanding Provision 1 of Item 4260-011-0001, Budget Acts of 2002 and 2003, the $10.3 million loan authorized to the Genetic Disease Testing Fund shall be fully repaid to the General Fund by June 30, 2006. This loan shall be repaid with interest calculated at the rate earned by the Pooled Money Investment Account at the time of the transfer."

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed.

12. Genetic Disease Testing Program—May Revision Caseload Adjustments

Issue: The DHS is requesting an increase of $1.5 million (Genetic Disease Testing Fund) due to caseload increases in the Newborn Screening Program and the Prenatal Screening Program. The DHS states that these additional costs are due to an increase in the number of tests performed.

According to the DHS, there has been a utilization increase of 47,160 tests over the current budget base and as such, a total increase of about $1.5 million (Genetic Disease Testing Fund)is needed. This is shown in the table below:

	New Born Program	Prenatal Program
Baseline Tests	530,889	374,884
2005-06 revised estimate	560,631	392,302
Total Additional Tests (47,160)	29,742	17,418
Cost per Test	$39.82	$17.27
Total ($1.5 million)	$1,184,326	$300,809

Subcommittee Staff Recommendation: No issues have been raised. It is recommended to **adopt** the May Revision as proposed.

Background on the Program: Genetic and congenital disorders are a serious health problem and a major cause of disability and death. The DHS operates two public health medical screening programs—the Newborn Screening Program and the Prenatal Screening Program. By legislative mandate, these screening tests may only be provided under these two programs. **Fees deposited in the Genetic Disease Testing Fund support both programs.**

The Newborn Screening Program screens over 500,00 newborns a year (99 percent) in 325 maternity hospitals. Laboratory services are provided under contract with eight private laboratories. Follow-up activities are secured by contract with other private institutions. A blood specimen is collected on special filter paper forms from each newborn at the hospital of birth and mailed to a designated regional laboratory. Identifying information and results of laboratory analysis are electronically provided to the DHS. Any positive tests or unsatisfactory specimens are noted and electronically transmitted to one of seven regional Newborn Screening Program test follow-up centers that track the case until evidence of a proper referral and treatment is received.

State law requires all medical practitioners to inform pregnant patients between 15 and 20 weeks of gestation of the availability of prenatal screening for serious birth defects. This is a voluntary screening. This blood test, the Expanded AFP (triple marker testing)—provides pregnant women with a risk assessment for major birth defects, including neural tube defects, abdominal wall defects, and chromosomal defects.

13. Lease Revenue Debt Service—Allocation of Set-Aside in Control Section 4.30 & Richmond Laboratory Project

Issue: The May Revision proposes to make a series of adjustments to the DHS budget for the purpose of allocating the set-aside contained in Budget Control Section 4.30 related to Lease Revenue Debt Service. In addition, it proposes a series of adjustments to reflect a reduction in base rental payments, fees, and insurance costs due to an updated debt service payment schedule for the Richmond Laboratory lease revenue project.

Specifically, the DHS budget is proposed to be increased by $1.809 as follows to reflect the set-aside for the Control Section 4.30:

- Item 4260-003-0001 be increased by $1.250 million
- Item 4260-003-0044 be increased by $60,000
- Item 4260-003-0080 be increased by $37,000
- Item 4260-003-0098 be increased by $14,000
- Item 4260-003-0203 be increased by $440,000
- Item 4260-003-0890 be increased by $8,000

The DHS budget also needs to be decreased by $2.7 million as follows for the Richmond Laboratory lease revenue project technical adjustments:

- Item 4260-003-0001 be decreased by $1.842 million
- Item 4260-003-0044 be decreased by $88,000
- Item 4260-003-0080 be decreased by $54,000
- Item 4260-003-0098 be decreased by $21,000
- Item 4260-003-0179 be decreased by $1,000
- Item 4260-003-0203 be decreased by $648,000
- Item 4260-003-0890 be decreased by $12,000

Subcommittee Staff Recommendation: No issues have been raised. It is recommended to **adopt** the May Revision as proposed.

14. Technical Adjustment to the CA Nutrition Network

Issue: The May Revision **proposes an increase in reimbursements of $372,000 (Reimbursements from the DSS which are federal funds) to the California Nutrition Network Program. This increase is proposed for the purpose of aligning available resources as included in the Department of Social Services (DSS) budget.**

The California Nutrition Network is a social marketing campaign that promotes health eating and physical activity among food stamp and other income households. The services provided through interagency agreements includes: (1) staff support for statewide public and private partnerships, planning and administration, including resource development, (2) research and evaluation, (3) media and supermarket interventions, (4) community interventions funded through over 190 local assistance contracts with a variety of local governments and community based organizations, (5) special projects of statewide significance to promote system and environmental change, (6) outreach and education services to improve access to the Food Stamp Program, and many more.

Subcommittee Staff Recommendation: This was a technical error in the Governor's January budget and the May Revision is proposing an adjustment for this purpose. Therefore it is recommended **to adopt the May Revision as proposed.**

15. Delta Dental Enrollment Staff for Provider Enrollment Functions

Issue: The May Revision requests **an increase of $997,000 ($281,000 General Fund) to fund an additional 7 Delta Dental provider enrollment positions. The DHS has existing authority to contract with Delta for this purpose.**

The DHS states that there is a backlog for the processing of dental provider applications in the Medi-Cal Program and these resources are needed for this purpose. This issue parallels the problems discussed previously by the Subcommittee regarding Medi-Cal Provider enrollment. This aspect of the problem is in the dental area (i.e., Denti-Cal).

Subcommittee Staff Recommendation: No issues have been raised. It is recommended to **adopt** the May Revision as proposed.

D. Item 0530 — CHHS Agency *(Vote Only)*

1. Request for Staff for Medicare Part D Coordination

Issue: The May Revision **requests an increase of $100,000 (General Fund) to fund a Career Executive Assignment (CEA I)** (two-year limited-term) position to provide oversight and coordination concerning the implementation of Medicare Part D implementation.

Subcommittee Recommendation: It is recommended **to reject the May Revision.** This is recommended for several reasons.

First, the administration is seeking staff resources in certain "operating" departments—Department of Aging (4 positions), Department of Developmental Services (4 positions at headquarters and 11.5 positions at the Developmental Centers), and Department of Mental Health (one at headquarters and 9 at the State Hospitals). Providing some additional resources in the operating departments makes sense.

Second, in the Budget Act of 2004, an increase of $1.8 million (General Fund) and 14 new positions were provided to the CHHS Agency. This action more than doubled the size of the agency in one-year.

Third, based on information obtained from the Agency as of April 20, 2005, there is an existing CEA position which is currently vacant. Therefore, this vacant position could be used for this purpose.

E. Item 1760 Department of General Services *(Vote Only)*

Issue: The Administration requests that Item 1760-001-0666 be increased by $429,000 to fund increased security costs for the State Capitol building.

Staff Recommendation: It is recommended to adopt the proposal.

II. ITEMS FOR DISCUSSION *(Shown by Department)*

A. Item 4280--Managed Risk Medical Insurance Board

(Also See DHS for Proposition 99 Items)

1. Healthy Families Program Estimate—Adjustments for May Revision

Issue: The May Revision proposes a series of technical adjustments for the Healthy Families Program (HFP). Total program expenditures are now estimated to be $959.4 million ($347.4 million General Fund, $601 million federal S-CHIP funds and $9.8 million in Reimbursements).

The May Revision reflects the following key adjustments:

- Increase of $47.9 million ($16.5 million General Fund) to fund an increased caseload of 78,117 children by June 30, 2006. It is estimated that the HFP will serve 867,418 children in 2005-06.
- Increase of $14.148 million ($5.106 million General Fund) to reflect an average 2.9 percent rate increase provided to the HFP participating plans. This pending rate increase was discussed before the Subcommittee in a prior hearing.

Background—Overall on the HFP (See Hand Out): The Healthy Families Program (HFP) provides health, dental and vision coverage through managed care arrangements to uninsured children (through age 18) in families with incomes up to 250 percent of the federal poverty level, who are not eligible for Medi-Cal but meet citizenship or immigration requirements.

The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until *at least* the age of two. If these AIM to HFP two-year olds have families that exceed the 250 percent income level, then they would no longer be eligible to remain in the HFP. Families pay a monthly premium and copayments as applicable. The amount paid varies according to a family's income and the health plan selected. Families that select a health plan designated as a "community provider plan" receive a $3 discount per child on their monthly premiums.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision as proposed.** No issues have been raised.

Questions:

1. MRMIB, Please provide a brief summary of the key aspects of the May Revision adjustments.

2. Administration's Proposed Language to Carve-Out CCS Program Kids in the Transfer of AIM Program Infants to the HFP

Issue: The May Revision **proposes trailer bill language that would provide explicit retroactive (up to 12-months) authority for authorization of services provided under the California Children Services (CCS) Program for infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program** who after June 30, 2004 elect to enroll their infants in the Healthy Families Program (i.e., AIM-linked infants in the HFP).

The MRMIB states that this legislation is necessary for the implementation of the AIM to HFP transfer enacted in the Budget Act of 2003, and accompanying trailer bill language.

The Administration states that the authority would be limited to services provided to treat the CCS eligible medical conditions of AIM-linked infants by CCS-approved providers. **This language would also provide that, for cases approved on a retroactive basis, the DHS may reimburse providers for CCS treatment costs of AIM-linked infants for services rendered prior to the time the infant becomes known to CCS. This will ensure that families of these infants are not required to pay for these specific services.**

The Administration's proposed trailer bill language is as follows:

Add Section 123929 to the Health and Safety Code:

"(a) Except as otherwise provided in this section and Welfare and Institutions Code section 14133.05, California Children's Services Program services provided pursuant to this Article require prior authorization by the department or its designee. Such prior authorization is contingent on determination by the department or its designee that:

- The child receiving such services is confirmed to be medically eligible for the CCS Program;
- The provider of such services is approved in accordance with the standards of the CCS Program; and
- The services authorized are medically necessary to treat the child's CCS eligible medical condition.

(b) Effective July 1, **2004**, the department or is designee may approve a request for a treatment authorization that is otherwise in conformance with Subdivision (a) for services for a child participating in the Healthy Families Program pursuant to the provisions of Section 12693.70(a)(6)(A)(ii) of the Insurance Code, received by the department or its designee after the requested treatment has been provided to the child.

(c) Effective July 1, **2004**, if a provider of services who meets the requirements of subdivision (a)(2) incurs costs for services described in subdivision (a)(3) to treat a child described in subdivision (b) who is subsequently determined to be medically eligible for the California Children's Services Program as determined by the department or its designee, the department

may reimburse the provider for such costs. Reimbursement under this section shall conform to the provisions of Section 14105.18 of the Welfare and Institutions Code.

Subcommittee Staff Recommendation: The language has been reviewed and discussed with some constituency groups. The proposed language is consist with the intent of the actions taken in the Budget Act of 2003. The language would help ensure that children with special medical needs receive appropriate CCS-level care when necessary. No issues have been raised. **Therefore, it is recommended to adopt the trailer bill language.**

Questions:

1. MRMIB and DHS, Please explain why this language is needed.
2. MRMIB and DHS, Does this language assist in drawing down federal S-CHIP funds?
3. MRMIB and DHS, Please explain why the language is retroactive to July 1, 2004.

B. Item 4260 Department of Health Services (*Discussion Items*)

MEDI-CAL PROGRAM ISSUES

1. Medi-Cal Baseline Estimate Package

Issue: The entire Medi-Cal Estimate is recalculated at the May Revision. As such, the Estimate package needs to technically be adopted as a baseline and then individual issues are adjusted as needed (as discussed in the issues noted in the Agenda, below).

The Medi-Cal Program local assistance expenditures for 2005-06 are estimated to be $29.4 billion ($12.962 billion General Fund), excluding special funds provided to hospitals. This reflects a *net* decrease of $39.4 million (increase of $16.1 million General Fund), based on the Governor's May Revision proposed policy changes. This is shown in the table below.

Summary Totals of Governor's May Revision for Medi-Cal Program

Component of the Medi-Cal Program	May Revision 2005-06	Change from Governor's January
Medical Care Services	$27,258 billion ($12,184 billion GF)	-$99.3 million (-$6.9 million GF)
County Administration	$1,875 billion ($682 million GF)	$67.3 million ($27.6 million)
Fiscal Intermediary	$320 million ($96.5 million GF)	-$7.4 million (-$4.6 million GF)
TOTAL	$29,452 billion ($12,962 billion GF)	-$39.4 million ($16.1 million GF)

Of the proposed $29.4 billion**, (1)** $27.258 billion is for Medical Care Services, **(2)** $1.875 billion is for County Administration and related items, and **(3)** $320 million is for the Fiscal Intermediary services, including EDS processing, Delta Dental processing and Maximus processing (as the health care options contractor for Medi-Cal Managed Care).

In addition to these expenditures, a total of $5.127 billion (all special funds and federal funds) is provided to fund payments for Disproportionate Share Hospitals, voluntary governmental transfers for supplemental hospital funding and capital debt projects for hospitals.

The DHS notes that the Medi-Cal Estimate does **not** reflect any adjustments related to the Administration's proposed Hospital Waiver. (The Hospital Waiver will be discussed later in this Agenda.)

The average monthly caseload for 2005-06 is projected to be 6.734 Medi-Cal enrollees which represents a decrease of 74,900 people, or 1.1 percent from the January budget.

Subcommittee Staff Recommendation for Baseline Adjustments: The Governor's May Revision contains the following key baseline adjustments in which the Subcommittee staff has raised no issues:

A. Two Plan Model Managed Care Expenditures (Existing Program): The May Revision proposes expenditures of $2.982 billion ($1.499 billion General Fund) for Medi-Cal enrollees who are receiving medically necessary services from one of the Two Plan Models. Each designated county has two competing managed care plans. These counties include Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. No issues have been raised regarding this item.

B. Geographic Managed Care (Existing Program): The May Revision proposes expenditures of $419.3 million ($210.6 million General Fund) for Medi-Cal enrollees who are receiving medically necessary services from a Geographic Managed Care Plan (plans located in Sacramento County and San Diego County). No issues have been raised regarding this item.

C. Quality Improvement Fee for Managed Care Plans: The May Revision proposes expenditures of $315.7 million (total funds) for implementation of this proposal by July 1, 2005. This fee was approved through the Budget Act of 2004 and was also discussed in our April 4th hearing. The federal CMS approval was finally granted as of March 10, 2005.The May Revision assumes the following:

- Six percent fee paid by plans — $198.8 million revenues
- Rate increase to be paid to plans — $315.7 million ($157.8 million GF)
  - Net increase to plans — $116.9 million
  - Net savings to the GF — $40.9 million

No issues have been raised regarding this item.

D. Long-Term Care Rate Adjustment: The May Revision proposes an increase of $59.9 million ($29.9 million General Fund) for a rate adjustment to Nursing Homes (Level A), Intermediate Care Facilities-Developmentally Disabled (ICF-DD) and related facilities, Managed Care (including PACE, COHS and others), Distinct-Part Nursing Facilities (DP-NFs), Rural Swing Beds, and Pediatric Subacute. This rate adjustment is effective as of August 1, 2005. This rate adjustment is in keeping with California's existing State Plan and rate methodology for these facilities.

The break out by facility category is as follows (figures are not adjusted for the lag factor as contained in the budget):

ICF-DD	8.96 percent increase	$3.4 million (total funds)
ICF-DD/H	3.94 percent	$8.7 million
ICF-DD/N	less than 1	$391,000

NF-Level A	5.98 percent	$600,000
Distinct Part/NF Level B	11.71 percent	$31.7 million
Rural Swing Beds	11.71 percent	$300,000
Subacute	5.08 percent	$12.8 million
Pediatric Subacute	5.97 percent	$3.4 million
Managed Care		$4.6 million

It should be noted that this rate adjustment reflects a two-year cost-of-living adjustment because the rates were frozen for one year (2003-04) as directed in the Budget Act of 2003.

(One facility type—Adult Day Health Care Centers (ADHCs) should also have received a rate adjustment but the Administration is proposing to freeze it. This issue is discussed under the ADHC issue below in this Agenda.)

E. Technical Request from DOF: The DOF has requested inclusion of $200,000 GF due to the need to correct for a technical error.

Questions:

1. DHS, Please provide a *brief* summary of the baseline adjustments for Medi-Cal.

2. Technical Adjustments to Medi-Cal Baseline--*Prior* Subcommittee Actions

Issue: In prior Subcommittee hearings, the Subcommittee has made adjustments to the Medi-Cal Program. The fiscal adjustments for these prior actions have changed because Medi-Cal enrollment, utilization and assumptions have changed at the May Revision due to updated data. Therefore, technical adjustments to these actions must be done.

The prior actions and their adjustments are as noted below. This action does not include any new proposals, just adjustments to prior actions.

Subcommittee Staff Recommendation: It is recommended to adopt the revised fiscal estimates for these actions in order to appropriately reflect the Subcommittee's prior actions.

A. S-CHIP Funding for Prenatal Care: The Subcommittee agreed to authorize the Administration to submit a State Plan Amendment to the federal CMS in order to draw down a 65 percent federal match. Trailer bill legislation was adopted for this purpose (no change to this prior action). The Medi-Cal May Revision slightly adjusts the savings level to reflect minor technical adjustments. **The savings level is now $191.728 million (General Fund).**

B. Rejected Administration's $1,000 Dental Cap: In the May 2nd hearing, the Subcommittee adopted a $1,800 dental cap with specified exemptions and no retroactivity. As such, there will be no savings for this action in the budget year.

The Administration's proposal assumes a savings level of $38.2 million ($19.1 million General Fund) at the May Revision (not including the increased cost for individuals with developmental disabilities which is addressed under the DDS item—See Vote Only). **As such, this savings level is rejected**. **The amount proposed for Delta Dental costs for preparation of establishing the dental cap needs to be maintained at a cost of $2 million ($500,000 General Fund).**

***C. Rejected Medi-Cal Premiums*:** In the April 4th hearing, the Subcommittee rejected the Administration's proposal to require certain Medi-Cal enrollees to pay premiums. The May Revision contains expenditures of $12.9 million ($6.5 million General Fund) for County Administration for the processing of premium payments. **These increased costs need to be deleted due to the rejection of the premium requirements.**

D. Rejected Changes to Single Point of Entry: In a prior hearing, the Subcommittee rejected the Administration's proposal to change the existing Single Point of Entry process by using a Contractor to perform certain functions presently done by County Welfare Departments. Therefore, the proposed net savings of $3.364 million ($2.159 million General Fund) needs to be deleted.

E. County Performance Monitoring Contractor Cost: In a prior Subcommittee hearing, the Administration's proposal to use a contractor to

monitor the counties performance was rejected **for savings of $600,000 ($300,000 General Fund).** Other performance measure actions were adopted at that time and are being maintained (relates to trailer bill language and state positions).

F. Disease Management Program: In a prior Subcommittee hearing, the Subcommittee reduced this program due to delays in implementation. The May Revision has also reflected the delay in implementation and a technical adjustment. **Therefore, it is recommended to conform to the Administration's expenditure amount of $2.250 million ($1.125 million General Fund) which is about $1.750 million (total funds) less than January.**

3. Administration's Proposal on Medi-Cal Drugs and Medicare Part D Interaction—*ISSUES "A" to "D"*

Overall Background: The Medicare Modernization Act (MAA) makes significant changes to the federal Medicare Program and as such, affects the state's Medicaid (Medi-Cal) Program. Part D of the MAA is the new outpatient prescription drug benefit that will be implemented as of January 1, 2006. As of this date, Medicare will begin to pay for outpatient prescription drugs through "Prescription Drug Plans (PDPs) or Medicare Advantage plans. Enrollment into these plans will include "dual eligibles"—individuals enrolled in both Medi-Cal and Medicare.

There are about 1.1 million Medi-Cal/Medicare enrollees (dual eligibles) in California. According to the DHS, about 137,000 of these individuals are enrolled in Medi-Cal Managed Care and 937,000 are enrolled in "fee-for-service" Medi-Cal.

According to the California Health Policy Forum, dual eligibles typically have incomes of less than $10,000 a year. Dual eligibles tend to be in poor health due to chronic illnesses and conditions such as diabetes, heart disease, dementia or a serious mental illness.

Medicare will contract with private plans to provide outpatient prescription drugs. The federal CMS has deemed California its own region for purposes of creating "Prescription Drug Plans (PDPs) competition (since California has the largest number of people in Medicare).

The Governor's May Revision continues to assume that Medicare will be responsible for all drug coverage for dual eligibles effective January 1, 2006, and no Medi-Cal drug benefit will be available to any Medi-Cal enrollee participating in Medicare, **except** for limited circumstances as discussed below.

The Governor's May Revision also includes a new outreach component and requests for increased state staff to address Part D issues. These issues will be discuss individually as shown below unless otherwise directed by the Chair.

Table 1: Governor's May Revision for Medi-Cal Due to Part D Drug Shift

Description of Component	**2005-06 (Half Year) (General Fund)**
1. Reduced Drug Costs in Medi-Cal: This savings level assumes elimination of dual eligible drug benefits, currently being paid by the Medi-Cal Program, beginning January 1, 2006. The federal Part D Program is to now provide most drugs. This savings level assumes that dual eligibles are about 56.85 percent of Medi-Cal's pharmacy expenditures. The DHS estimates that the federal Part D Program will cover 94.11 percent of the dual eligibles expenditures. The remaining 5.89 percent of costs are discussed below.	-$759.6 million (savings)
2. Loss of Drug Rebate: It is anticipated that the shift from Medi-Cal drug coverage to the Medicare Part D coverage could weaken the DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions. No affect is anticipated for 2005-06, but losses will occur in 2006-07.	N/A
3. "Clawback": Federal law requires states to make a "state contribution" payment to help finance Part D dual eligibles. The May Revise has adjusted this "clawback" downward by about $135 million from the January budget which reflected a $646 million figure.	$511 million (expenditure)
4. Medi-Cal Coverage for Drugs Not Covered by Part D: The May Revision proposes to have Medi-Cal continue to pay for Medi-Cal drug coverage for those categories of drugs excluded by Part D. These categories of drugs include weight loss drugs, barbiturates, benzodiazepines, over-the-counter drugs, cough and cold medications, and various medical supplies.	$46.8 million (expenditure)
5. DHS Adjustment for Medi-Cal Managed Care: The Part D requirement will result in lower Managed Care capitation payments for Managed Care plans for the drug services that will be covered under Part D. This savings was not recognized in the January budget.	$57.6 million (savings)
Proposed Net Impact for Budget Year	$259.5 million (savings)

The DHS has also provided a projected estimate for 2006-07 (full-year of implementation). This estimate is shown in the table below.

Table 2-DHS Projected Estimate for 2006-07 for Drug Shift

Description of Component	**2006-07 (General Fund)**
1. Reduced Drug Costs in Medi-Cal	-$1.830 billion (savings)
2. Loss of Drug Rebate	$539.7 million (expenditure)
3. "Clawback"	$1.291 billion (expenditure)
4. DHS Adjustment for Medi-Cal Managed Care	-$115.2 million (savings)
5. Medi-Cal Coverage for Drugs Not Covered by Part D	$112.8 million (expenditure)
Projected Net Impact for 2006-07 (budget + one year)	**$1.9 million (savings)**

ISSUE "A"—Shift of Drugs from Medi-Cal to Medicare Part D

Issue: The May Revision assumes implementation of the federal Part D Program by January 1, 2006 as directed by the MAA. **As shown in the table below, there are three key components to the baseline program—(1)** the shift of 94.11 percent of the dual eligibles drug expenditures to the federal Part D Program, **(2)** the loss of future drug rebate funds from this shift, and **(3)** the state's contribution to the federal government.

2005-06 (January 1, 2006, **Half-Year**)

1. Reduced Drug Costs in Medi-Cal: This savings level assumes elimination of dual eligible drug benefits, currently being paid by the Medi-Cal Program, beginning January 1, 2006. The federal Part D Program is to now provide most drugs. This savings level assumes that dual eligibles are about 56.85 percent of Medi-Cal's pharmacy expenditures. The DHS estimates that the federal Part D Program will cover 94.11 percent of the dual eligibles expenditures. The remaining 5.89 percent of costs are discussed below.	-$759.6 million (savings)
2. Loss of Drug Rebate: It is anticipated that the shift from Medi-Cal drug coverage to the Medicare Part D coverage could weaken the DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions. No affect is anticipated for 2005-06, but losses will occur in 2006-07.	N/A
3. "Clawback": Federal law requires states to make a "state contribution" payment to help finance Part D dual eligibles. The May Revise has adjusted this "clawback" downward by about $135 million from the January budget which reflected a $646 million figure.	$511 million (expenditure)

The DHS has approached the federal CMS to readjust the "clawback" formula to include rebates paid in 2004 for the 2003 year. This adjustment would reduce the state's clawback that is to be paid to the federal government. To-date the DHS has been unsuccessful in this effort.

It should also be noted that no additional county administration funding for eligibility processing has been provided by the DHS.

The DHS is also proposing trailer bill language as follows:

Add Section 14001.11 as follows:

"14001.11 (a) The department shall implement the federal requirements described in Section 1398u-5 of Title 42 of the United States Code.

(b) **In each of the several counties of the state, the eligibility and enrollment functions required** under Section 1396u-5(a)(2) and (3) of Title 42 of the United States Code, which may include, but are not limited to, determining eligibility and offering enrollment for premium and cost sharing subsidies made available under and in accordance with Section 1395w-114 of Title 42 of the United States Code, **shall be a county function and responsibility, subject to the direction, authority, and regulations of the department.**

(c) **Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all county letters, provider bulletin, or similar instructions.**

Thereafter, the department ***may*** adopt regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code.

(d) The department shall seek approval of any amendment to the state plan necessary to implement this section as required by Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.). Nothwithstanding any other law and only when all necessary federal approvals have been obtained, this section with the exception of the Phased-Down State Contribution as described in 42 U.S.C. Section 1396u-5(c)(1)(A)-(C), shall be implemented only to the extent federal financial participation is available."

Subcommittee Staff Recommendation: It is **recommended to (1)** approve these fiscal three components of the DHS proposal, **(2)** modify the DHS language to require the DHS to include counties and appropriate stakeholders in the development of the all-county letters or other forms of instruction that are sent out, and **(3)** modify the DHS language to require them to work with the counties to develop an estimate of cost for this eligibility processing which is to be presented in the Governor's 2006-07 budget submittal to the Legislature.

Questions:

1. DHS, Please provide a brief summary of the components as noted in the table.
2. DHS, Has the federal CMS taken into consideration any of California's previous cost containment in this area or related concerns with the high amount of the state's clawback?

ISSUE "B"—Medi-Cal Managed Care Plan Capitation Savings Due to Federal Part D Drug Benefit

Issue: The Governor's May Revision reduces by $115.2 million ($57.6 million General Fund) the capitation rate paid to certain Medi-Cal Managed Care plans. The DHS states that since the federal Part D Program will be providing drug coverage for dual eligibiles, an adjustment in the capitation rate paid by the state to plans for dual eligibles (i.e., aged, blind, disabled and long-term care) enrolled in Medi-Cal Managed Care is warranted. Therefore, the proposed adjustments reflect the enrollment level of dual eligibles in each plan.

The DHS is proposing the following adjustments (January 1, 2006 to June 30, 2006):

Medi-Cal Managed Care Plan	Total Funds	General Fund Savings
County Organized Health System	$93.3 million	$46.7 million
Two Plan/GMC Model/Other	$21.9 million	$10.9 million
Total *Savings* (half-year)	$115.2 million	$57.6 million savings

Subcommittee Recommendation: It is **recommended to adopt the May Revision as proposed.** At this point in time, there appears to be no other better estimate.

Questions:

1. DHS, Please describe how these savings were calculated.
2. DHS, Will a revised methodology be used for next year when more information regarding the federal Part D Program is known?

ISSUE "C"—Medi-Cal Coverage for Drugs Not Covered by Part D, & Advocacy Concerns with Continuity of Care Issues

Issue: The May Revision **proposes an increase of $93.6 million ($46.8 million General Fund) to continue to pay for Medi-Cal drug coverage for those categories excluded from the federal Part D Program.**

This is a change from the Governor's January budget which proposed to not cover any drugs for the dual eligibles that the federal Part D would not pay for. Clearly there are concerns from all involved about ensuring that gaps in the federal Part D Program are filled in—at least to some degree.

Specifically, the categories which are excluded from the federal Part D coverage that the DHS is going to cover include the following. The DHS estimated expenditures assume a January 1, 2006 implementation which corresponds to the federal program (half year).

Drug Category	Total Fund Amount
Barbiturates/Benzodiazepines	$9.241 million
Over-the-Counter, Cough & Cold	$44.3 million
Weight Loss Drugs	$ 180,000
Biologicals	$5.2 million
Potassium Chloride	$2.3 million
Part B Medi-Cal (Drugs covered by under Part B Medicare& Medical)	$17 million
Medical Supplies (incontinence/intravenous and other)	$23 million
Total Amount	$101.2 million
Total Budget (adjusted for cash and payment lag factor)	**$93.6 million** **($46.8 million GF)**

According to the DHS, these categories comprise 6.31 percent of the dual eligibles expenditures based on 2003 data and information provided by the federal CMS. **However, the DHS states that Part D coverage and Medi-Cal coverage may change as additional information becomes available.** In fact, the DHS will not know what the new Prescription Drug Plans (PDPs) will be offering until after the Budget Act for 2005 is completed.

The Administration is also proposing the following trailer bill language:

Add Section 14133.23 to Welfare and Institutions Code:

(a) It is the intent of the Legislature to comply with the Medicare Modernization Act, which provides federal drug benefits to Medicare beneficiaries. To the extent that federal financial participation is not available, **the Legislature intends to eliminate the provision of drug benefits under this chapter to full-benefit dual eligible beneficiaries** who are eligible for drug benefits under Part D of Title XVII of the Social Security Act (42 USC Section 1395 w-101 et

seq.) or under an MA-PD plan under Part C of Title XVIII of the Social Security Act (42 USC 1395w-21 et seq.).

(b) (1) Notwithstanding any other provision of law, commencing January 1, 2006, ***only*** **drug benefits for which federal financial participation is available shall be provided under this chapter to a full-benefit dual eligible beneficiary.**

(2) As a benefit under this chapter, **the department, subject to the approval of the Department of Finance and only to the extent that federal financial participation is available**, **may elect to provide a drug or drugs in a class of drugs not covered** under Part D of Title XVIII of the Social Security Act (42 USC 139w-101 et seq) or under an MA-PD pan under Part C of Title XVIII of the Social Security Act (42 USC 1395w-21 et seq.) to full-benefit dual eligible beneficiaries.

(3) As a benefit under this chapter, and only to the extent that federal financial participation is available, the department shall provide a drug or drugs to full-benefit dual eligible beneficiaries who are otherwise eligible to receive such a drug or drugs due to their entitlement under Title 42 US Code, Chapter 7, Subchapter XVIII, Part A or their enrollment under Title 42 US Code, Chapter 7, Subchapter XVIII, Part B.

(4) **Except as provided under paragraph (3), nothing in this section shall be interpreted to require the department to provide any drug or drugs not covered under Part D of Title XVIII of the Social Security Act (42 USC 1395w-101 et seq.) or under an MA-PD plan under Part C of Title XVIII of the Social Security Act (42 USC Section 1395w-21 et seq) if federal financial participation is not available.**

(c) The **department shall seek approval of any amendments** to the state plan necessary to implement this section as required by Title XIX of the Social Security Act (42 USC 1396 et seq).

(d) **Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret or make specific this section by means of all county letters, provider bulletins, or similar instructions**. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) For the purposes of this section, a “full-benefit dual eligible beneficiary” means an individual who:

(1) Is eligible or would be eligible for coverage for the month for covered Part D drugs under a prescription drug plan under Part D of Title XVIII of the Social Security Act (42 USC Section 1395w-101 et seq.) or under an MA-PD plan under Part C of Title XVIII of the Social Security Act (42 USC Section 1395w-21 et seq.) and

(2) Nothwithstanding any other provision of this section, is determined eligible for full scope services, including drug benefits, for which federal financial participation is available.

(f) Subdivisions (a) and (b) of this section shall become operative on January 1, 2006.

The Governor's May Revision does *not* address any of the following concerns with the new federal Part D Drug Program:

- *Transition Period (from Medi-Cal to new PPD):* The DHS has also approached the federal CMS to grant a 3 to 6 month or so transition period to maintain continuity of care. (This would require a federal regulation change.) However, the federal CMS is not interested in providing any longer transition period as yet.

- *Cost Sharing:* Under the Part D Program, dual eligibles will have to pay new co-payments of $1 to $5 to get each prescription. The Governor's May Revision does not provide any assistance. In addition, dual eligibles may have to pay additional monthly premiums for drug coverage if they need to enroll in a prescription drug plan above the benchmark plan (i.e., low-cost plan) in order to obtain access to their particular existing drugs (such as certain anti-psychotics and HIV/AIDS drugs

Constituency Group Concerns—Transition Period, Wrap Around, Premiums, and Cost Sharing: Various constituency groups have raised concerns regarding the transition period, wrap-around coverage, new premiums and new cost sharing arrangements for dual eligibles who must now enroll in a Prescription Drug Plan (PDP).

Transition coverage is being requested in order to mitigate potential lapses in coverage as the dual eligibles go from Medi-Cal to the new Prescription Drug Plan (PDP). Specifically, the following three transition aspects are raised:

- *Continuity of Care:* There should be continued drug coverage by Medi-Cal and/or the new Prescription Drug Plan (PDP) for those drugs currently taken by the dual eligible in order to prevent disruptions of coverage and to allow for an appropriate transition to new drug formularies and appeal processes.
- *Access to Emergency Drug Supplies:* There should be access to "emergency" drug coverage for those dual eligibles who may need them during and after the transition period. Access to emergency drug coverage should be provided by the DHS and/or new Prescription Drug Plan (PDP). Medicare does not require drugs to be covered pending an appeal as does the Medi-Cal Program. Therefore a disabled person or frail, elderly individual might need some medication while pursuing the appeal.
- *Use "Troubleshooting" Mechanisms:* The DHS and federal government need to fund and authorize beneficiary assistance and troubleshooting systems that enable beneficiaries and their representatives to resolve eligibility and enrollment problems in a timely and effective manner.

"Wrap-around" coverage pertains to those drugs that are covered under the federal Part D Program but are not covered by a particular Prescription Drug Plan (PDP). If wrap-around is not provided, constituency groups note that the dual eligibles will have to pay the full cost of needed non-formulary drugs if they are unsuccessful in appealing for coverage of the drug through their Prescription Drug Plan (PDP).

Subcommittee Recommendation: The following actions are recommended:

- **(1)** Approve the increase of $93. 6 million (total funds) in order to provide drugs to dual enrollees for those categories of drugs excluded from the federal Part D Program;
- **(2)** Reject the Administration's proposal trailer bill language
- **(3)** Adopt placeholder trailer bill language to implement the federal Part D Program by January 1, 2006;
- **(4)** Adopt placeholder trailer bill language to provide drugs to dual enrollees for those categories of drugs excluded from the federal Part D Program as long as federal funds are available for this purpose;
- **(5)** Adopt placeholder trailer bill language for the DHS to develop a process for providing emergency drug coverage for **a dual eligible for up to 60-days during the first year of implementation of the federal Part D program**. The intent is to have the DHS develop a process in fall 2005 and to notify the Joint Legislative Budget Committee as to its content and potential cost. The cost could then be presented in the Governor's January budget (revised 2005-06 and 2006-07). This timeframe will also enable the DHS to have a better idea as to whom is warded the PDP contracts and what drugs are to be offered and more of how the program is to operate.

  Such a plan would provide for a transition during the first year. Again, the intent would be for emergency coverage—such as for antipsychotics, HIV/AIDS drugs, anti-seizure or other specified classes of drugs or conditions. This is such an unknown and important transition

Questions:

1. DHS, Please provide a brief summary of the proposal.
2. DHS, What drug categories will not be covered?
3. DHS, When may the state know more about implementation of the federal program as far as providing transition coverage?

ISSUE "D"—Federal Part D Program Interaction with the ADAP

Issue: California's Aids Drug Assistance Program (ADAP) also interacts with the implementation of the federal Part D Drug Program.

ADAP works with other third party payers to (1) make sure that ADAP is the payer of last resort, and (2) ensure that access to treatment and drugs are maintained for the ADAP eligible population in order to maintain health of HIV positive people.

Currently, the ADAP has paid share of cost payments for HIV positive Medi-Cal enrollees who could not afford to pay them. This is because it was cost-beneficial for the state to do so. **Beginning January 1, 2006, the ADAP will no longer cover share-of-cost for this population. This is because these individuals will not be eligible for the federal Part D Drug Program.**

Constituency Concern: The Subcommittee is in receipt of propose trailer bill language to provide for a cross-walk between the state's ADAP and the new federal Medicare Part D Program. This proposed language is as follows:

> "The department subsidizes the cost of these drugs for persons who do not have private health coverage, are not eligible for Medi-Cal, or cannot afford to purchase the drug privately. The subsidy program is funded through state and federal sources. The department may also subsidize certain cost-sharing requirements for persons with existing non-ADAP drug coverage by paying for prescription drugs included on the ADAP formulary in up to but not excluding the amount of that cost-sharing obligation. This cost-sharing may only be applied when the ADAP payment is allowed by the other payer. **This cost-sharing may only be applied when the ADAP payment is allowed to be the other payer."**

The intent of this language is to enable the ADAP Program to pay for the copays associated with the new federal Part D Program, as is presently done in the existing ADAP Program. This language is not intended to go outside the structure of the existing ADAP parameters.

Background—How Does AIDS Drug Assistance Program Serve Clients? ADAP is a subsidy program for low and moderate income persons (individual income cannot exceed $50,000) with HIV/AIDS who have no health care coverage for prescription drugs and are *not* eligible for the Medi-Cal Program. On average, ADAP clients access the program an average of 7.4 months per year.

ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, infected individuals would be forced to (1) postpone treatment until disabled and Medi-Cal eligible or (2) spend down their assets to qualify for Medi-Cal. About 50 percent of Medi-Cal costs are borne by the state, as compared to only 28 percent of ADAP costs.

Under the program eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor**.** The state provides reimbursement for drug therapies listed on the ADAP formulary (about 153 drugs currently). The formulary includes anti-retrovirals, opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics.

Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly Active Antiretroviral Treatment (HAART) which minimally includes three different anti-viral drugs. Studies consistently demonstrate that early intervention, minimizes more serious illness, reduces more costly treatments and

Subcommittee Recommendation: It is **recommended to adopt the above language as "placeholder" language and to meet with the DHS prior to Conference Committee to technically work out any issues regarding how the language would be made operational.**

Questions:

1. DHS, From a technical assistance basis, please comment on the language.

4. Proposed Elimination of Medicare HMO Premiums Due to Federal Part D

Issue: The May Revision proposes **to eliminate paying the monthly premium for 40,000 existing individuals (dual eligibles) who are presently enrolled in Medicare HMOs. This would occur as of January 1, 2006, when the federal Part D Drug Program is implemented.**

Beginning January 1, 2001, the Medi-Cal Program began paying a monthly premium to certain HMOs that have enrolled Medi-Cal/Medicare dual eligibles. Premium payments are made to ensure that individuals will remain enrolled and that Medi-Cal will avoid paying the pharmacy costs for these individuals. **However, because of the Part D Program, the May Revision assumes that the last premium payment for these individuals will be December 2005.**

As such, it is very likely that these 40,000 individuals will leave managed care and re-enroll into Medi-Cal Fee-for-Service.

Subcommittee Staff Recommendation: If desired, the Subcommittee could continue to fund the premium payment for the remainder of the 2005-06 fiscal year (from January 1, 2006 to June 30, 2006) in order to provide for a transition period for these individuals**. If this is desired, an increase of $13.1 million ($6.5 million General Fund) would be needed. This would provide for coverage for an additional 7 months, through to June 30, 2006.**

Questions:

1. DHS, Please explain the May Revision proposal.
2. DHS, How are people going to be notified and what are the potential consequences?

5. Administration's Proposal on Medicare Part D—Outreach & Administrative Function Changes in Medi-Cal

Issue: The Governor's May Revision proposes several changes within the Medi-Cal Program related to outreach activities and administrative function changes due to the pending implementation of the federal Part D Program. These outreach and administrative adjustments within the Medi-Cal Program are as follows:

- ***A. Enrollee Outreach:*** The Administration is proposing an increase of $2.2 million ($1.1 million General Fund) in Medi-Cal to print and mail flyers to dual eligibles. The DHS states that the DMH and DDS will design the flyers specifically geared to the special needs of the consumers that they serve. The DHS is doing the printing and mailing since the names and address of the Medi-Cal/Medicare dual eligibles is confidential. It is assumed that 6 mailings will go out within the 2005-06 fiscal year.

- ***B. Provider Relations:*** The Administration is proposing an increase of $1.7 million ($463,000 General Fund) to support provider relations activities at the Fiscal Intermediary (i.e., EDS). The DHS states that additional EDS staffing is needed to provide training and offer telephone assistance and clarifications on claims processing changes. Further, there will be costs for provider notification and education activities, such as provider bulletins, notices and internet messaging actions.

- ***C. Adjudicated Claims Lines Reductions:*** The DHS states that savings of $3.1 million ($1.5 million General Fund) will be recognized due to less claims processing due to the shift in drug coverage.

- ***D. Treatment Authorization Request (TAR) Reductions:*** The DHS assumes savings of $5 million ($1.2 million General Fund) from the reduced processing of TARs related to drug coverage.

- ***Eligibility Systems Changes:*** The DHS proposes an increase of $2 million ($204,000 General Fund) to enter into a contract for eligibility system changes, phase-down validation, production of federal Part D required data files, and related functions. The DHS states that Medi-Cal processing must be modified to ensure proper identification, tracking and reporting of the recipient population to be covered by the federal Part D Program. System modifications will need to be made to several systems including the Medi-Cal Eligibility Data System (MEDS), Fiscal Intermediary Access to Medi-Cal Eligibility (FAME), claims data file and to generate new reports. The federal CMS will require the DHS to submit a monthly file of dual eligibles for verification processing. An enhanced federal matching rate of 90 percent will be obtained for these changes.

Questions:

1. DHS, Please provide a brief summary of these proposed changes.

Subcommittee Staff Recommendation: It is recommended to approve these changes as proposed.

6. Adult Day Health Care Program—*Several Issues*

Issues: The Governor's May Revision proposes several changes to the Adult Day Health Care (ADHC) Program. Each of these is outlined below.

As discussed in the Subcommittee's May 9th hearing, recent conversations with the federal CMS have clarified that California must eventually submit a federal Waiver (not a State Plan Amendment) in order to maintain our Adult Day Health Care Program. This conclusion was just recently solidified with the federal CMS even though conversations have been ongoing about this program since 2003.

The DHS states that implementation of an ADHC Waiver by Spring of 2007 is anticipated. However, this timeline is probably optimistic. Transitioning to a Waiver Program will require considerable fore thought particularly given federal requirements pertaining to cost-neutrality, eligibility, service structure and relates aspects. Any ADHC Waiver will also require state statutory change as well as federal CMS approval. Policy bills are currently moving regarding the state statutory change. Clearly, it is unknown how long it may take the federal CMS to review and approve an ADHC Waiver.

The Governor's May Revision proposes the following adjustments:

- ***Moratorium:*** The May Revision proposes savings of $45.7 million ($22.9 million General Fund) to the ADHC by continuing the "moratorium" implemented through the Budget Act of 2004 and accompanying trailer bill language. This proposed savings level assumes that no changes are made to existing statute. Further, it is assumed that any moratorium will remain in place until a federal Waiver is approved to change the program.

- ***Rate Freeze and Trailer Bill Language:*** This is a new proposal intended to replace the "rate redesign" proposal made in the Governor's January budget. Since the rate redesign proposal cannot commence due to the need to obtain a federal Waiver first, a rate freeze is being proposed.

  The proposed rate freeze assumes an implementation date of June 30, 2005, and "*cost avoids*" $21.9 million ($11 million General Fund). The January rate redesign proposal would have saved $11.3 million ($5.7 million General Fund). The rate freeze would be in effect until the federal CMS established an effect date for a Waiver or set forth a new reimbursement rate methodology for ADHCs.

  Under existing statute, the ADHCs would receive a 5.8 percent rate increase effective as of August 1, 2003 that equates to $21.9 million (total funds).

  The average monthly cost per participant in an ADHC is $717.82. Currently Medi-Cal reimburses ADHCs at a "bundled rate"—a single rate which is paid per recipient, per day (minimum of a four-hour stay required). This rate is set at 90 percent of the state's reimbursement rate for Nursing Facility—Level A.

This rate structure was the **outcome of a legal settlement agreement** done in 1993. Therefore, the Administration is also proposing trailer bill legislation to negate those aspects of the settlement agreement that pertain to the rate being linked to Level A nursing facilities.

This rate includes payment for all required ADHC services as specified in Title 22, California Code of Regulations. This list of required services includes, among other, physical therapy, occupational therapy, speech therapy and recipient transportation to and from the ADHC facility.

- ***Request for DHS State Staff:*** The DHS has submitted a Finance Letter which requests an increase of $48,000 ($24,000 General Fund) to hire an Associate Governmental Program Analyst position beginning January 1, 2006 and ending January 1, 2008. The purpose of this position would be to assist in the restructuring of the ADHC Program.

Any federal Waiver proposal by the DHS would require state statutory change prior to implementation. The Administration is sponsoring policy legislation—AB 1258 (Daucher)—on this issue and it is proceeding through that process.

In addition, SB 642 (Chesbro) is also proceeding through the policy committee process and it would, among other things, make statutory changes to enable the DHS to obtain a federal Waiver for the ADHC Program as well.

Prior Subcommittee Hearing and Constituency Request for Changes to the Moratorium: In the May 9th hearing, the Subcommittee discuss proposed changes to the existing moratorium as presented by the CA Association of Adult Day Services. This proposal language would do the following:

- Address a specific need in the San Francisco area regarding the Laguna Honda nursing facility and a need to utilize community-based resources;
- Allow ADHC provider expansion in Imperial County due to the number of low-income seniors residing in the county;
- Address a specific need in Napa County, as noted (see page 2 of hand out);
- Address a specific need in Humboldt County, as noted; and
- Enable 25 older adults with developmental disabilities to be phased-in for services as noted.

Based on technical assistance provided by the DHS, enactment of the proposed language as outlined above would increase ADHC expenditures by $376,000 ($188,000 General Fund) for 2005-06. Estimated 2006-07 expenditures would be $1 million ($500,000 General Fund).

Background Over All—Existing Program: Adult Day Health Care (ADHC) is a community-based day program which provides nursing, physical therapy, occupational therapy, speech therapy, meals transportation, social services, personal care, activities and supervision designed for low-income elders and younger disabled adults who are *at risk* for being placed in a nursing home. There are about 300 ADHC facilities in the state that are certified in the Medi-Cal Program.

ADHC has been a successful model for elderly individuals for they can obtain many services in one location. The general concept behind providing ADHC services is that they delay or defer individuals from going into nursing homes or other more costly forms of care and therefore, it saves Medi-Cal money**.** Compared to the monthly Medi-Cal cost of a nursing home at about $3,400 per month, ADHC can cost as much as three to four times less. Currently, there are about 43,000 Medi-Cal recipients who receive ADHC services in any given month.

Typically, each ADHC has the capacity to serve between 40 and 100 clients per day. According to the LAO, about 56 percent of the total number of ADHCs are located in Los Angeles County.

Subcommittee Recommendation: One of the purposes of implementing the "moratorium" was to freeze the program in place until a federal Waiver or State Plan Amendment could be crafted and put into place. The moratorium was meant to be a temporary measure. The trailer bill language proposed by CAADS is a very modest lessening of the moratorium.

The rate freeze and accompanying trailer bill language are questionable due to the legal settlement in effect since 1993. If the Administration thinks the legal settlement should be re-crafted, then discussions with the plaintiffs could occur to seek other remedies rather than a unilateral proposal. Therefore, it is recommended to reject the trailer bill language.

The overall recommendation is to **(1)** adopt placeholder trailer bill language to modify the moratorium as noted in the agenda, **(2)** increase by $376,000 ($188,000 General Fund) for the change in the moratorium, **(3)** reject the proposed trailer bill language to negate the 1993 settlement agreement regarding rates in ADHCs, **(4)** increase by $21.9 million ($11 million General Fund) to reflect the existing required rate increase (effective as of July 1, 2005), and **(5)** approve the Finance Letter for the DHS position.

Questions:

1. DHS, Please provide a brief description of the May Revision proposal.

7. Federal Funds for Local Trauma Centers

Issue: The Budget Act of 2003 and accompanying trailer bill language authorized Los Angeles and Alameda counties to transfer funds to the Medi-Cal Program to be matched with federal funds through Medi-Cal. The funds for this transfer come from counties taxes as adopted by local voters.

The DHS is to use these funds to offset the costs of care at local trauma care centers throughout the two counties. Payments are expected to begin September 1, 2005 and are to be retroactive to July 1, 2003. The DHS states that they did not obtain approval of a State Plan Amendment until March 31, 2005. As such, the Trauma Care Centers have not been able to receive payments as yet.

The total federal share available is as follows:

• 2003-04 retroactive payment	$7.2 million
• 2004-05	$10.7 million
• 2005-06	$11.2 million
Total Amount	$29.1 million (federal funds)

The Governor's May Revision reflects **yet another implementation date change** from January 1, 2005 to September 1, 2005. Will the revised date be met?.

Subcommittee Staff Recommendation: It is recommended to adopt the May Revision but the DHS needs to assure that the funds will begin to flow as of September 1, 2005.

Questions:

1. DHS, Please provide a status update regarding the pending federal CMS approval?
2. DHS, Please describe how these funds will be allocated to the trauma care centers.

8. Medi-Cal Drug Budget—Implementation of "Protect State Rebates"

Issue: Through the **Budget Act of 2002, and accompanying trailer bill legislation, the DHS proposed savings of $14 million ($7 million General Fund) related to protecting the state's supplemental rebate program**.

Specifically, this issue pertains to how the federal government views some of our rebates in the context of the overall drug manufacturer law. Federal Medicaid drug rebate law requires drug manufacturers to pay state rebates based on a percentage of their average manufacturer's price or the difference between their "best price" and their average manufacturer price. Payments are made to the states each quarter based on the manufacturers' calculation of the AMP for each drug product they sell. Federal law allows manufacturers to recalculate the AMPs on a retroactive basis that affects payments made to states for past quarters. **This has resulted in states, including California, having to pay back or give manufactures a credit towards future rebate payments.**

The DHS noted that since Medi-Cal also collects state supplemental rebates (i.e., rebates based on contractual agreements that are in addition to the federally mandated rebates), and since these supplemental rebates are often based on the manufacturer's AMP, California is affected by retroactive changes in the manufacturers AMP. **As such, this has resulted in the loss of millions of dollars in rebates (both federal and state).**

Governor's May Revision: The Governor's May Revision lists the "protect state rebates" as part of its overall drug budget reduction within the Medi-Cal estimate package but it **does not reflect any savings for 2005-06.** Instead, it says that the issue is pending federal CMS approval of a State Plan Amendment.

Subcommittee staff has obtained updated information from the DHS. Apparently, the federal CMS is not now going to require submittal of a State Plan Amendment but instead, the DHS must submit a revised drug rebate contract for federal CMS approval. This document should be sent to the federal CMS by May 2005.

Subcommittee Recommendation: It is recommended to reduce the Medi-Cal drug budget by $3.5 million (General Fund) by assuming completion and approval by the federal CMS of California's request which has been pending now for three years with the DHS. The DHS notes that once CMS approval is obtained, they will need to redo some of the contracts on drug rebates. **Therefore, the proposed savings of $3.5 million (General Fund) reflects only a half-year potential.**

Questions:

1. DHS, What is the status of getting the needed information to the federal CMS?

9. Administration's Trailer Bill Language for Three Medi-Cal Benefits

Issue: The Governor's May Revision proposes three pieces of trailer bill legislation and budget adjustments as follows:

- ***Speech-Generating Devices Rate Increase:*** An increase of $100,000 ($50,000 General Fund) is requested to reflect a rate increase for speech-generating devices. This proposed increase would **settle litigation issues** by providing adequate access to the product. The DHS is also requesting trailer bill language to enable these devices to be paid the lesser of either 100 percent of the Medicare cost, or a contract price as specified.

- ***Therapeutic Diabetic Shoes and Inserts:*** The Administration proposes trailer bill legislation to add therapeutic diabetic shoes and inserts as a Medi-Cal benefit. The Administration assumes that the cost of adding this benefit would be offset by the savings that would occur in other areas of the program.

- ***Portable X-Ray Transportation Rate Increase:*** The Administration proposes trailer bill legislation to increase the rates paid for portable x-ray transportation to 100 percent of the Medicare rate. The Administration assumes that the cost of providing this benefit would be offset by the savings that would occur in other areas of the program.

Subcommittee Staff Recommendation: It is recommended to approve the proposed trailer bill legislation and budget adjustments as proposed. Clearly these changes are needed to improve access to these services.

Questions:

1. DHS, Please provide a brief summary of each of these proposals.
2. DHS, After these changes are made will appropriate access to these services be available statewide?

10. Stanislaus –Two Plan Model Contract (Existing Program)

Issue: Stanislaus County is a Two-Plan Model Medi-Cal Managed Care county. (This means that the DHS is supposed to contract with two managed care plans in the county. **One plan is supposed to be a "local initiative" and the other plan is a commercial plan** (i.e., non-government operated). Children and families are enrolled on a mandatory basis in one of the managed care plans, whereas aged, blind and disabled individuals are enrolled on a voluntary basis or can access fee-for-service Medi-Cal.

In Stanislaus County, fee-for-service was restored as an option beginning in 1999 because the commercial plan—Omni—terminated its contract. As such, Medi-Cal enrollees had the choice of enrolling into the Local Initiative or using Medi-Cal fee-for-service.

In the Spring of 2003, the DHS released a "Request for Proposal" to obtain a new contractor. HealthNet was awarded the contract to operate the commercial plan and is expected to begin operations as of August 2005.

The Governor's May Revision proposes an increase of $3.9 million ($1.9 million General Fund) in 2005-06 to account for the conversion. This is an estimate since the rates for the new commercial plan (HealthNet) are not yet available. Projected capitation has been calculated using the rates paid to the Local Initiative in Stanislaus. Rates are therefore assumed to be 95 percent of fee-for-service.

It should be noted that one large hospital within the county has refused to contract with HealthNet. Therefore, the DHS is proceeding to carve-out a five zip code area around the hospital that will continue to be fee-for-service and use Blue Cross. The rest of the county will use the Two Plan Model (Local Initiative and HealthNet).

Subcommittee Recommendation: Subcommittee staff has raised no issues with the proposed budget adjustment since it is primarily due to a payment lag factor associated with Medi-Cal making cash/accrual accounting adjustments. However, discussion of the conversion and how it was done is important given the Administration's proposed expansion of Medi-Cal Managed Care.

Questions:

1. DHS, Please briefly describe why it has taken from 1999 to 2005 for a second plan to be obtained for Stanislaus County.

11. Managed Care Intergovernmental Transfer for Rate Increase--CalOPTIMA & San Mateo COHS's

Issue: The University of California system and San Mateo County are both transferring funds to the state (DHS) for the purpose of providing capitation rate increases. Specifically, these proposed Intergovernmental Transfers (IGTs) are as follows:

- University of California system for CalOPTIMA $7.5 million
- San Mateo County for their COHS $4 million

- Total Transfer Amount = $11.5 million

This $11.5 million amount is used to draw down the federal match of $11.5 million. As such, $15 million will be provided to CalOPTIMA (Orange County) and $8 million will be used by the Health Plan of San Mateo for capitation rate increases.

Subcommittee Staff Recommendation: It is recommended to approve as proposed.

Questions:

1. DHS, Please briefly summarize the May Revision proposal and why this IGT would meet federal CMS approval?

12. DHS Provided Three Percent Rate Increase for CalOptima

Issue: The Governor's **May Revision proposes an increase of $18.4 million ($9.2 million General Fund) to provide CalOptima (Orange County) with a three percent rate increase effective as of October 1, 2005.**

The DHS states that this rate increase is needed because CalOptima is experiencing severe financial difficulties. **The DHS states that this rate increase is needed to avoid the plan's insolvency which has been projected by the plan to occur as early as 2007-08.**

The DHS states that CalOptima is experiencing financial difficulties as reported in their quarterly financial statements. Losses have occurred in eight of the last nine quarters and the plan continues to deplete financial reserves. The last three quarter losses have resulted in an average loss margin of 3.5 percent (negative profit rate). The DHS states that at this loss rate, the plan's operations are unsustainable. CalOptima has reported to the DHS that its equity position will fall below the required regulatory tangible net equity level in 2006-07. **It should be noted that CalOptima also received a three percent rate increase last year in the Budget Act of 2005.**

Background on Capitation Rates: Capitation rates for CalOptima are negotiated between the plan and the California Medical Assistance Commission (CMAC). The DHS state's that due to the state's fiscal problems over the last four years, CalOptima's negotiated capitation rates have significantly lagged behind inflationary trends in the health care industry. Adding to this situation is that the current CalOptima's rates are well below the fee-for-service equivalent costs.

Medi-Cal Managed Care Rate Structure: Questions regarding the existing Medi-Cal Managed Care rate structure have been evolving for several years. As noted by the LAO in past Analyses, the existing methodology is outdated.

Though the DHS did change its methodology in 2003 in order to meet federal law requirements to be actuarially based, amongst other things, the DHS does not use encounter data to make rate determinations.

The "base cost" is the part of the rate that relates to experience from the past. Generally, to calculate the base cost, an attempt is made to find a group of individuals that will be similar to the group for which the rates are being set. Claims tapes for four COHS's is used for determining the Two Plan Model rates. Various adjustment factors are applied to the base costs, such as for age/sex population mix, enrollee's duration of Medi-Cal enrollment, trend factors for hospital inpatient and outpatient services, trend factors for pharmacy, and other factors. In addition, changes made through the state budget process are also to be factored in as part of the process.

Currently there are contract provisions that provide for an administrative remedy and an appeals process when disputes are raised by the plans regarding contract issues. These provisions are included in the Two Plan Model, Geographic Managed Care and the COHS contracts. Specifically, there is (1) an initial "notice of dispute"

process, (2) an administrative appeals process, and (3) a Writ of Mandate process which is filed with the Superior Court to protest the Administrative Appeal decision. Within the last two-years, 15 plans have filed some form of Administrative Appeal regarding rates. Four cases have been taken to Superior Court.

The DHS notes that they have recently awarded a contract to Mercer which begins May 1, 2005. Expenditures in the current year for this contract are expected to be $300,000 (total funds) and $1 million for 2005-06.

Subcommittee Staff Recommendation: It is **recommended to (1)** adopt the May Revision as proposed to provide the needed rate adjustment to CalOptima, and **(2)** adopt Budget Bill Language to require the DHS to provide the Legislature with the results from the Mercer rate analysis. **The following Budget Bill Language is proposed (Item 4260-001-0001):**

> "The Department shall provide to the fiscal and policy committees of the Legislature the quantitative analyses and key data results obtained from the rate study being conducted by an independent contractor. This information shall be provided on a flow basis, when applicable and by no later than March 1, 2006. No proprietary or confidential information is being requested by this language."

Questions:

1. DHS, Please specifically describe how this rate increase was determined and why it is needed.
2. DHS, How does the DHS monitor for plan fiscal solvency issues and the appropriateness of Medi-Cal Managed Care rates?

13. Alameda Alliance for Health—Issue of Fiscal Solvency

Issue: The Alameda Alliance for Health is the Local Initiative in the Two Plan Model in Alameda County. Based on recent enrollment figures, there are 78,000 Medi-Cal enrollees in this plan.

Alameda is experiencing fiscal solvency issues, similarly to CalOptima. **As such, the Subcommittee is in receipt of trailer bill language as follows:**

> "A supplemental rate increase for Medi-Cal services of 5 percent shall be provided to the Alameda Alliance for Health for fiscal years 2005-06 through 2008-09.
>
> The Alliance shall provide a corrective action plan to the Department of Health Services that illustrates that, with the rate increase, the Alameda Alliance for Health is positioned to maintain solvency for the period of the rate increase and beyond.
>
> The department shall conduct periodic audits during the period of the rate increase to ensure compliance with the corrective action plan and to ensure that solvency is maintained."

Over the past five years, as with most counties, the safety net services in Alameda have been severely threatened due to the cost of providing services to the uninsured and the inadequacy of Medi-Cal reimbursement rates. As such, the Alameda Alliance for Health has depleted its reserves. **The Alameda Alliance is working with the Department of Managed Health Care on a corrective action plan for fiscal solvency. However, even with changes in order to avoid falling below the tangible net equity requirements in the first quarter of 2006, the Alameda Alliance must receive a rate increase of five percent.**

Over the past decade and a half, Alameda County has enacted several organizational reforms aimed at improving the access and cost effectiveness of its system. It consolidated the administration of its two acute hospitals, closing one emergency room and reducing its medical surgical beds. It has invested heavily in new outpatient facilities, both county and community based organization operated, and targeted both discretionary Tobacco Master Settlement Funds and newly enacted sales tax revenue to expand serve and access. Services expansions included innovative partnerships with school districts and private hospitals.

Despite these commitments and gains, the system is threatened by inadequate reimbursement rates and a dwindling provider base willing and able to address populations of special need.

Subcommittee Staff Recommendation: It is **recommended to (1)** appropriate $6.1 million ($3 million General Fund) to provide for the rate increase in 2005-06, ***and* (2)** adopt the above trailer bill language as shown.

14. DHS Hospital Waiver Update

Issue: The Subcommittee has discussed numerous times the many evolving components of the pending federal Waiver regarding hospital financing.

Grave concern has been expressed regarding the magnitude of the issue and how it affects California's overall health care system, particularly the safety net hospitals. The late timing of the negotiations with the federal CMS and lately federal OMB has also been disconcerting (our existing Waiver expires as of June 30, 2005). The state's health care system is at significant risk.

Questions:

1. DHS, Please provide an update on the status of the federal Waiver overall.
2. DHS, Please provide an update on each component piece of the funding.
3. DHS, Please provide an update on the policy changes regarding any coverage product, requested federal changes to California's Medi-Cal Program and related matters.
4. DHS, What are the next steps?

15. Administration's Proposal to Expand Medi-Cal Managed Care— *ISSUES "A" to "B"*

Issue and Prior Subcommittee Hearings: As discussed in several Subcommittee hearings, the Administration is proposing an aggressive expansion of the Medi-Cal Managed Care Program. This expansion would be achieved through a phased-in process **over a twelve to eighteen month period** commencing in January 2007. It is anticipated that **816,000 *additional* Medi-Cal enrollees would be added during this period.** Of this amount, 554,000 are aged, blind, and disabled.

The proposed expansion assumes the following **key components**:

- ***Mandatory enrollment of aged, blind and disabled individuals:*** This enrollment would need to be implemented in the 12 Two-Plan Model counties (two plans in each county), the two GMC counties and the 13 new counties. Voluntary enrollment is the present option in use (i.e., one chooses to enroll). There are about 290,000 aged, blind and disabled individuals who are enrolled presently, or less than 10 percent of the total 3 million Medi-Cal Managed Care enrollees. **The proposed mandatory enrollment would add about 554,00 aged, blind and disabled individuals, or about twice the number of individuals presently enrolled.** About 74 percent of these individuals are in the SSI/SSP Aid to the Disabled category.

- ***Expansion to 13 New Counties:*** The Administration would expand Medi-Cal Managed Care to 13 additional counties, including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

  The Administration assumed the following Managed Care model configurations for these new counties:

  - Include El Dorado and Placer counties in the existing Sacramento GMC;
  - Include Imperial County in the existing San Diego GMC;
  - Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
  - Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

  The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

  It should be noted that federal law currently restricts California from having more than the five COHS which are presently in operation (i.e., five COHS's in eight counties). As such, if Ventura or another individual county wants to become a COHS, then a federal law change is required. Further, federal law also mandates

that not more than 14 percent of all Medi-Cal enrollees can participate in the COHS model.

ISSUE "A"—Policies on Expansion and Mandatory Enrollment

Issue and Prior Subcommittee Hearings: As discussed in several prior Subcommittee hearings, the Administration proposal would require (1) state statutory changes, (2) approval of a federal Waiver, and (3) adoption of state regulations (though the Administration may choose not to use the regulation process for some or all program components).

Subcommittee Recommendation: Based on discussions from several Subcommittee hearings, the following actions are recommended:

- ***1. Reject Administration's Trailer Bill Language:*** This language proposed a mandatory enrollment of aged, blind and disabled individuals and provide complete carte blanch authority to the Director of the DHS to do any type of sole source contracting for services, and to seek any type of federal Waivers for this purpose. The proposed language completely lacked any involvement of the Legislature and did not contain any language regarding improvements to the core Medi-Cal Managed Care Program.

- ***2. Allow Existing County Organized Health Care Systems to Expand to New Counties:*** Some of the 13 new counties may be interested in merging into an existing COHS. For example, Marin maybe interested in joining the Partnership Health Plan COHS. It should be noted that the DHS will need to submit a Waiver revision to the federal CMS for changes to be made to the COHS model.

  It should also be noted that a federal law change would be needed for any county wanting to be its own COHS since federal law limits California to a total of five COHS's, which we presently have in operation.

  By the nature of the model, COHS's require the mandatory enrollment of aged, blind and disabled individuals. Therefore, counties that choose to become part of an existing COHS would have mandatory enrollment and would also need to meet the following conditions regarding the CCS Program and plan readiness.

- ***3. Allow Expansion for Managed Care Using Existing Program Enrollment Method***: For those counties (of the 13 counties) that choose to (1) join an existing GMC model, (2) establish their own GMC model, or (3) establish a Local Initiative to commence with implementation of a Two-Plan Model, they may proceed with operating under the existing arrangements—i.e., mandatory enrollment of children and families, and voluntary enrollment of aged, blind and disabled.

- ***4. Carve Out of California Children's Services (CCS) Program:*** Existing statute "carves-out" the CCS Program from Medi-Cal Managed Care until September 1, 2008, except for certain County Organized Health Systems (COHS). With the proposed expansion recommendation, it is recommended to adopt the following trailer bill language as placeholder to enable COHS to expand, as noted, but to also retain the integrity of the CCS Program. The proposed placeholder language is as follows:

  "When a managed care contractor authorized to provide CCS covered services pursuant to subdivision (a) of Welfare and Institutions Code Section 14094.3 proposes to expand to other counties, the contractor shall demonstrate how it will maintain and comply with California Children's Services Program (CCS) standards including, but not limited to: referral of newborns to the appropriate neonatal intensive care level, referral of children requiring pediatric intensive care to CCS-approved pediatric intensive care units, and referral of children with CCS eligible conditions to CCS approved inpatient facilities.

  The managed care contractor shall demonstrate how it will comply with CCS program medical eligibility regulations. Questions about interpretation of the state CCS medical eligibility regulations, or disagreements between the county CCS program and the managed care contractor regarding interpretation of those regulations, shall be resolved by the local CCS program consulting in writing with the appropriate CCS regional office or state CCS staff. The response shall be communicated in writing to the managed care contractor.

  The managed care contractor shall demonstrate how it will ensure the timely referral of children with special health care needs to CCS paneled providers who are board certified in both pediatrics and in the appropriate pediatric subspecialty.

  The managed care contractor shall demonstrate how it will report expenditures and savings separately for CCS covered services and CCS eligible children.

  All children who are enrolled with a managed care contractor who are seeking CCS program benefits shall retain all rights to appeals and fair hearings of denials of medical eligibility or of service authorizations. Information regarding the number, nature, and disposition of appeals and fair hearings shall be part of an annual report to the Legislature on managed care contractor compliance with CCS standards, regulations, and procedures. This report shall be made available to the public.

  The state, in consultation with stakeholder groups, shall develop unique pediatric plan performance standards and measurements, including, but not limited to the health outcomes of children with special health care needs."

- ***5. "Plan Readiness":*** In a March document, the DHS describes how they intend to determine a "plans readiness" for becoming operational to provide services to Medi-Cal enrollees. As such, it is recommended to adopt placeholder legislation that corresponds with the DHS document (codify key components and intents).

- ***6.Adopt Placeholder Trailer Bill Language—Reporting to Legislature:*** It is also recommended to adopt placeholder trailer bill legislation to require the DHS to do the following:

  - Provide the Legislature with a quarterly update, beginning January 10, 2006, on core activities to improve the Medi-Cal Managed Care Program and to

expand to the 13 counties. This update shall include key milestones and objectives of progress regarding changes to the existing program, submittal of State Plan Amendments to the federal CMS, submittal of any Waiver documents and related key functions related to the expansion effort.

Questions:

1. DHS, Any comment regarding the proposal?

ISSUE "B"—Administration's Request for Staff & Contract Funds

Issue: The DHS is requesting a total **increase of $7.6 million** ($3.3 million General Fund and $4.3 million federal funds) to **(1)** hire **47.5 new state staff as of July 1, 2005**, **(2)** provide $1 million for external contracts, and **(3)** provide $1.9 million for "interdepartmental" contracts.

This request for resources assumed the mandatory enrollment of aged, blind and disabled individuals.

The table below provides a summary of where the 47.5 requested positions would be located and also displays the 2006-07 anticipated future request for next year. This proposed staffing level by the Administration assumes legislative approval of their entire managed care proposal—13 new counties, mandatory enrollment in all counties of aged, blind and disabled individuals, **and** implementation of the Alternative Long-Term Care Integration Program (not, just the newly scaled down three Pilots).

Table 1: **Summary of Administration's Staffing Proposal**

DHS Divisions & CMAC	New Positions for 2005-06 **(Budget Year)**	New Positions for 2006-07 **(Next Year)**	Total Positions
Medi-Cal Managed Care	22.0	14	36
Payment Systems	8.5	0	8.5
Long-Term Care	8.0	0	8
Administration	5.0	3.0	8
Legal Services	4.0	0	4
CA Medical Assist. Commission	0	3	3
Totals	**47.5 Requested**	20.0 Future	67.5

The following discussion outlines the position request by each area.

Medi-Cal Managed Care Division (22 positions, or 40 percent of the budget request):
The DHS states that existing staffing levels have been significantly depleted over the last 18 months to 24 months as a result of the budget deficit, resulting positions cuts, and the extended hiring freeze instituted by the Governor, which has resulted in about a 30 percent reduction of staff within the DHS Medi-Cal Managed Care Division. As such, they are requesting 22 new positions.

Table 2—Medi-Cal Managed Care Division Request *(22.0 positions)*

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Services Manager II	Coordinate activities for the expansion	1.0
Staff Services Manager I	Oversee contract development and operational issues	2.0
Associate Gov Prog Analysts	Provide additional contract management for new contracts in the expansion counties.	8.0
Associate Management Auditor	Conduct ongoing financial monitoring of contracted health plans in the new counties and work with actuary staff in development of experienced-based rates for both the expansion areas *and* aged/blind/disabled	2.0
Office Technician	Perform duties due to expansion	1.0
Nurse Consultant III	Develop new policies and procedures relative to clinical standards, policies, and quality measures for quality of care	1.0
Medical Consultant II	Support special needs services	1.0
Nurse Evaluator II	Develop medical monitoring protocols and tools for expansion population.	2.0
Research Program Spec II	Support rate methodology and encounter data research	1.0
Research Program Spec I	Support rate methodology and encounter data research	1.0
Actuary Positions	Make actuarial valuations and verify capitation rates	2.0
Total for the Division		**22.0**

Payment Systems (8.5 positions):

Table 3—DHS Payment Systems Division *(Two Areas)*

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
A. Health Care Options	Conduct materials development, system modification and contract amendments with Health Care options contractor (Maximus)	**6.0 total**
Staff Info Systems Analyst		2.0
Associate Gov Prog Analysts		2.0
Research Program Specialist I		1.0
Office Technician		1.0
B. Fiscal Intermediary & Provider Relations	Oversee written communications, training materials and serve as DHS resource for provider activities (billing questions and claims processing)	**2.5 total**
Office Technician		0.5
Total for the Division		**8.5 total**

Long-Term Care (8 positions):

Table 4—DHS Long-Term Care Division

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Services Manager II	To coordinate and provide liaison with other programs and state departments.	1.0
Staff Services Manager I	To supervise 6 staff and to develop ALTCI policies.	1.0
Associate Gov Prog Analysts	To provide ALTCI policy development and oversight.	4.0
Nurse Evaluator II	To provide review and evaluation of current clinical outcome measures and clinical practice guidelines.	1.0
Office Technician	To provide administrative support	1.0
Total for the Division		**8.0**

Administration Division (5 positions):

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Personnel Specialist	Process workload with the requested positions	0.5
Associate Gov Prog Analyst	Perform contract management	1.0
Research Program Specialist II	Develop and maintain complex data projects for the Fiscal Forecasting Branch	1.5
Account Technician	Process additional workload	1.0
Office Assistant	Support to the contract processing activities	1.0

Legal Services (4 positions):

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Counsel III	To perform contracting work and drafting procurement documents related to managed care expansion.	1.0
Staff Counsel I	To perform contracting work and drafting procurement documents related to managed care expansion.	1.0
Staff Services Manager I	For the Office of Regulations, though the trailer bill language assumes little if any regulations.	1.0
Associate Gov Prog Analyst	For the Office of Regulations, though the trailer bill language assumes little if any regulations.	1.0

Contract Funding Request: The DHS is also seeking about $3 million (total funds) in additional contract funds for 2005-06. These contract funds would be used as follows:

- ***Health Care Options Contract ($300,000 for 2005-06)***: Maximus is the Medi-Cal Managed Care "enrollment broker" who (1) presents the plan choices to the pending managed care enrollee, and (2) defaults enrollees to plans as needed if a choice is not made. The DHS states that costs are calculated based on enrollment. The projected costs for 2005-06 are $300,000 (total funds) for them to (1) develop new enrollment materials, (2) revise existing enrollment materials, and (3) begin system change work for the development of new informing materials specific to the aged, blind and disabled populations. Expenditures for the out-years would increase.

- ***Fiscal Intermediary (Electronic Data Systems Contract) (total funds not specified by the DHS):*** The DHS states that changes would need to be made to the "adjudicated claim line" process as well as other aspects.

- ***External Quality Review Organization ($312,000 total funds):*** The EQRO is an accrediting body that is an expert in the scientific review of the quality of health care provided to Medi-Cal enrollees in a state's managed care program. It activities are required by federal law. It is unclear however what specifically would be done with these funds.

- ***Translation Services—University of California System ($190,000 total funds):*** The DHS presently has a consultant services contract with the UC to translate written Medi-Cal Managed Care informing materials for Medi-Cal enrollees. This would include expenditures for both the proposed geographic expansion as well as the proposed mandatory enrollment of aged, blind and disabled.

- ***Independent Assessment of Waivers ($210,000 total funds):*** These funds would be needed only if the Legislature grants the DHS authority to seek a federal Waiver for the mandatory enrollment of aged, blind and disabled individuals. Further, it is unclear as to why funds would be needed in 2005-06 when the DHS assertive schedule shows that enrollment would not commence until at least January 1, 2007.

- ***Information Technology Contract ($1.215 million total funds)***: This proposed expenditure of $1.215 million ($304,000 General Fund) would be for "systems changes" to (1) develop of programming specifications, (2) coordination of the Health Care Options vendor (Maximus), (3) development of materials for training new counties about the Medi-Cal Eligibility Determination System related data, (4) development of changes to plan tables, (5) assessment of HIPAA related changes, (6) assessment of changes to paid claims data, (7) coding of system changes, (8) testing of system changes, and (9) coordination of external testing with counties.

- ***Outreach to Aged, Blind and Disabled ($500,000 total funds):*** The DHS states that these funds are needed if mandatory enrollment of aged, blind and disabled individuals is done.

- ***Long-Term Care Diversion Assessment Tool ($500,000 total funds)***: It is the intent of the state to have the ALTCI plans work with a contractor on the development and implementation of a uniform Long-Term Care Diversion and Assessment Protocol for seniors and adults with disabilities. This protocol would be used to determine functional needs and preferences and to ensure that seniors and adults with disabilities receive care that supports maximum community integration and self-direction. **This contract is part of the proposed Acute Long-Term Care Integration Projects.**

Legislative Analyst Office Comment and Recommendation: The LAO notes that once the Legislature has decided what aspects of the Administration's proposed Medi-Cal Managed Care proposal it wants to proceed with, then it can decide what necessary DHS staff components and contract amounts are necessary.

For example, if the Legislature wants to proceed with expansion of the existing Managed Care Program (i.e., children and families, and voluntary enrollment of aged, blind and disabled) into new geographic areas, then less DHS resources would be necessary in 2005-06.

However, at a minimum, the LAO would recommend deleting at least 5.5 of the requested DHS 47.5 positions for savings of $469,000 (General Fund), and to make four of the positions two-year limited-term appointments.

Questions:

1. DHS, Please present your request for staff resources and for contract funding.
2. DHS, Are all of the identified contract funds necessary in the budget year?

17. Long-Term Care Integration Assistance *(Pre-Cursor to ALTCI)*

Issue: The Legislature authorized planning grants commencing in 1998 to facilitate the integration of long-term care services as a result of state and local interest in creating a more efficient delivery system for seniors. The first grants were allocated by the DHS in 1999. A total of $2.6 million (General Fund) has been awarded to 16 counties between 1999 and 2004. Both San Diego and Contra Costa counties have sustained ongoing planning efforts and were the first entities to receive "implementation" grant awards (total of $897,500) in 2004-05 to precede with various integration activities.

The May Revision continues to provide $898,000 (General Fund) for these integration purposes. However, it is unclear on how these funds are to be allocated by the DHS given the newly proposed ALTCI Projects (as discussed below).

In addition, the DHS is seeking an increase of $236,000 ($118,000 General Fund) to continue 3 limited-term positions that expire as of June 30, 2005. The DHS is asking to extend these positions for one more year (to June 30, 2006).

Subcommittee Staff Recommendation: **First,** after discussion with the CHHS Agency, the following Budget Bill Language is recommended to be added to Item 4260-101-0001 to direct the allocation of the $898,000 to the Acute Long-Term Care Integration Projects.

> "Of the amount appropriated in this Item, $898,000 shall be directed from the long term care integration pilot project set forth in Article 4.3 (commencing with Section 14139), of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, and made available to the director for use by local entities implementing Acute and Long Term Care Integration Projects and shall be available only for reimbursable start-up costs approved by the director of the Department of Health Services."

Second, it is recommended to approve continuation of the three positions for one more year.

Questions:

1. DHS, Please provide a brief explanation of the request.

18. Acute & Long-Term Care Integration Projects (Three Only)— *Revised Language*

Issue: The Subcommittee has discussed this issue in several hearings. The Administration has revised their proposal for developing Acute and Long-Term Care Integration Projects. Under their revised language, it is clarified that three projects would be created in three county areas--Contra Costa, Orange and San Diego.

However, the Subcommittee is still waiting receipt of a second revision that was promised by the Administration and is late. The Administration notes that revised draft language (#2) is still pending delivery. It is a work in progress overall.

The Subcommittee has also received considerable comment from a variety of constituents and stakeholders. This information has been very constructive and clearly, further discussions are necessary.

Subcommittee Staff Recommendation: It is **recommended to adopt placeholder trailer bill language for implementation of the three proposed Acute Long Term Care Projects with the intent to continued discussions over the next few weeks**. For purposes of sending the language to Conference Committee it is recommended to (1) adopt placeholder language regarding the development of rates, and (2) adopt placeholder language regarding the use of public authorities for personal care services.

Questions:

1. DHS, When will revised language (#2) be available for review?
2. Public Comment—key issues and ideas.

19. Administration's Trailer Bill Language for LA County Outpatient Clinics

Issue: The Administration is proposing trailer bill language that would permanently establish in state statute the cost-based reimbursement methodology presently provided in Los Angeles County for Los Angeles County owned or operated hospital clinics and community care clinics that participated in the Los Angeles County Waiver (set to expire as of June 30, 2005).

The federal Waiver for Los Angeles (second period from 2000 to June 30, 2005) enabled **LA-County outpatient hospitals (except emergency rooms) and clinics the opportunity to attain Federally Qualified Health Center (FQHC) designation and thereby, enhance their Medi-Cal reimbursement rate (the rate was would now be "cost-based").**

According to the DHS, federal CMS rules have changed and they will not now designate hospitals as FQHC. There are **presently 33** LA County owned and operated community care clinics that have not achieved FQHC status. These 33 clinics fall under the categories of outpatient departments of various hospitals, comprehensive health centers, Juvenile Court health centers, and other various health centers.

Therefore when the LA County Waiver expires as of June 30, 2005, the enhanced FQHC rate these 33 clinics are receiving will no longer be applicable without a state statutory change. The DHS notes that if the cost-based reimbursement is not continued, the DHS will need to revert these clinics back to a blended local code rate and over the long-term, this will further destabilize the LA County health care system.

Approval of the Administration's proposed trailer bill will enable the DHS to submit a State Plan Amendment to the federal CMS to allow cost-based reimbursement to a strictly defined category of outpatient hospitals and clinics.

The Administration's proposed trailer bill language is as follows:

Add Section 14105.24 to Welfare and Institutions Code:

(a) Clinics and hospital outpatient departments, except for emergency rooms, owned or operated by LA County that participated in the CA Section 1115 Medicaid Demonstration Project for Los Angeles County and received 100 percent cost-based reimbursement pursuant to the Special Terms and Conditions of that Waiver shall continue to be reimbursed under a cost-based methodology on and after July 1, 2005.

(b) Reimbursement to hospitals and clinics described in subdivision (a) shall be at 100 percent of reasonable and allowable costs for Medi-Cal services rendered to Medi-Cal beneficiaries. Reasonable and allowable costs shall be determined in accordance with applicable cost-based reimbursement provisions of the following regulations and publications:

(1) The Medicare reimbursement methodology as specified at Sections 405.2460 through 405.2470 of Title 42 of the Code of Federal Regulations (together with applicable definitions in Subpart X of Part 405 of title 42 of the Code of Federal Regulations to the extent those definitions are applied by the department in connection with payments to FQHCs in California).

(2) Cost reimbursement principles outlined in Part 413 of Title 42 of the Code of Federal Regulations. In the event of a conflict between the provisions of Part 405 and Part 413, the provisions of Part 405 shall govern.
(3) "Cost Principles for State, Local, and Indian Tribe Governments" (OMB Circular A-87)
(4) "Rural Health and FQHC Manual" (CMS Publication 27).
(5) Subdivision (e) of Section 14087.325 of the Welfare and Institutions Code, and any implementing regulations.

(c) The methodology for reimbursement adopted by the state to comply with Section 1396a (aa) of Title 42 of the US code shall not be applicable to clinics that are paid pursuant to this section.

(d) This section shall become operative on the effective date established by the federal CMS for an amendment to the CA Medi-Cal State Plan that approves the cost-based reimbursement methodology for the clinics described in subdivision (b).

(e) Notwithstanding subdivision (a) of Section 14105 of the Welfare and Institutions Code and the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer the cost-based rates of reimbursement described in this section by means of provider bulletins or manuals, or similar instructions.

Subcommittee Staff Recommendation: It is recommended to approve the proposed trailer bill legislation.

Questions:

1. DHS, Please present the May Revision proposal.

20. Third Party Liability—Request for State Staff and Estimated Savings

Issue: The DHS is requesting a total increase of $5.850 million ($1.741 million General Fund), including an adjustment in the May Revision, to fund positions to increase and expand the functions of the Third Party Liability Program which is operated by the DHS to "cost avoid" and recoup payment for Medi-Cal services as allowed under both state and federal law. The table below is a summary of the DHS request and the LAO recommendation. (Please note the table does not display the federal fund match due to space constraints, but there is one.)

Summary Table #1—Governor's Request and LAO Recommendation

Proposal Component	DHS Positions	DHS General Fund	LAO Positions	LAO General Fund
1. Enhanced Estate Recovery & ACM				
Senior Tax Representative Supervisor	2	$46,122		
Program Technician	2	28,252		
Tax Compliance Representative	5	93,247		
Program Technician II	6	91,139		
Staff Information System Analyst	1	25,491	1	25,491
Associate Information System Analyst	3	71,163	3	71,163
SUBTOTAL	**19.0**	**$355,414**	**4.0**	**$96,654**
2. Statutory Changes to Increase Asset Recovery Collections				
Program Technician II—**May revise deleted**	~~4~~	~~$60,759~~		
Staff Counsel I—**May revise (delete 2)**	~~3~~ 1	~~157,442~~ 52,480		
Staff Counsel III	1	68,608		
Associate Governmental Prog Analyst	1	44,371		
SUBTOTAL	~~**9.0**~~ **3.0**	~~**$331,180**~~ **$165,180**	**0**	**0**
3. Recover Expenses from Managed Care Enrollees				
Senior Tax Representative Supervisor	1	$23721		
Senior Tax Representative Specialist	1	23,721		
Program Technician	1	14,126		
Tax Compliance Representative	5	96,545	4	77,236
Program Technician II	4	60,759	2	30,380
SUBTOTAL	**12.0**	**$218,872**	**6.0**	**$107,616**
4. Increase Other Health Identification				
Supervising Program Technician I	1	$15,604	1	$15,604
Program Technician	14	197,766	14	197,766
SUBTOTAL	**15.0**	**$213,370**	**15**	**$213,370**
5. Increase HIPP Enrollment				
Supervising Program Technician II	1	$16,438		
Program Technician II	5	75,949		
Program Technician	3	42,379		
SUBTOTAL	**9.0**	**$134,766**	**0**	**0**
6. Increase Recoveries from Private Health Insurance Center Billings				
Senior Tax Compliance Rep, Supervisor	1	$23,061	1	$23,061
Tax Compliance Representative	6	111,896	6	111,896
SUBTOTAL	**7.0**	**$134,957**	**7.0**	**$134,957**

Proposal Component (Page 2)	DHS Positions	DHS General Fund	LAO Positions	LAO General Fund
7. Fiscal Management Resources				
Accounting Administrator	1	$49,609		
Accounting Officer	1	39,933	1	39,933
Accounting Analyst	1	37,299	1	37,299
Accounting Technician	2	60,759	1	30,380
Associate Accounting Analyst	3	138,367	2	92,245
SUBTOTAL	**8.0**	**$325,967**	**5.0**	**$199,857**
8. Personnel Management Branch				
Associate Personnel Analyst	1.5	$45,464	1.0	$30,279
SUBTOTAL		**$45,464**		**$30,279**
9. Automation—Health Coverage Identification (One-Time cost)	**N/A**	**$146,650**	**N/A**	**$146,650**
TOTAL General Fund Amount	~~**80.5**~~	~~**$1.907 million**~~	**38.0**	**$929,000**
May Revision Adjusted	**74.5**	**$1.741 million**		
TOTAL Federal Fund Amount		$4.397 million		$1.941 million
TOTAL ALL FUNDS		$6.3 million		$2.870 million

Summary Table #2—Estimated Savings in 2005-06 from Above Positions (DHS and LAO)

Proposed Activity (Corresponds to activity and number from above)	DHS General Fund Savings	LAO General Fund Savings	Difference General Fund
1. Enhanced Estate Recovery & ACM	none in 2005-06	N/A	N/A
2. Statutory Changes to Increase Asset Recovery Collections *(May Revise adjusted)*	$1.7 million	0	$1.7 million (less savings)
3. Recover Expenses from Managed Care Enrollees	$718,500	$718,500	--
4. Increase Other Health Identification	$4.1 million	$4.1 million	--
5. Increase HIPP Enrollment	$583,000	--	$583,000 (less savings)
6. Increase Recoveries from Private Health Insurance Center Billings	$1.450 million	$1.450 million	--
9. Automation—Health Coverage Identification	$19.452 million	$19.452 million	--
Total Estimated Savings	**$28 million**	**$25.704 million**	**$2.283 million (less savings)**

The DHS proposes to augment staff in the **Third Party Liability Recoveries area by establishing a revised total of 74.5 positions (31 are two-year limited-term appointments) as noted above.** The DHS contends that the increased revenue and cost savings generated by the proposed enhancements creates a high return on investment.

There are a number of federal and state laws that pertain to third party recovery. Federal law requires states to seek reimbursement from estates of certain deceased Medi-Cal enrollees and to ensure that Medicaid (Medi-Cal) is the payer of last resort for those medical expenses caused by third party torts. Federal law also requires states to utilize third party information, within 60-days of receipt, to establish the existence of a liable third party before a claim for payment is filed. Information exchange (data matches) with private health insurance carriers is authorized in state law.

The DHS has authority to recover from liable private insurance carriers any payments made by Medi-Cal when the private carrier is determined to have primary payment responsibility.

There is also a state mandate to pay private health insurance premiums for eligible Medi-Cal enrollees when it is cost effective to do so. In addition the provisions for payment of Medicare Part A and Part B premiums on behalf of eligible Medi-Cal enrollees are also part of the state's agreement with the federal CMS for the state's Medi-Cal Program.

Legislative Analyst's Office Recommendation: The LAO is recommending **(1)** approval of 38 of the revised 74.5 positions for an increase of $1.941 million ($929,383 General Fund) in state support, and **(2)** adoption of a revised local assistance savings figure of $25.7 million (General Fund)

Subcommittee Staff Recommendation: Subcommittee staff concurs with the LAO recommendation.

Questions:

1. DHS, Please provide a brief summary of each of the component areas and explain each of the requests for resources.
2. LAO, Please explain your recommendation.

21. Medi-Cal Drug Rebate Accounting and Information System (RAIS)

Issue: The May Revision proposes an increase of $1.830 million ($457,000 General Fund) to fund a "refresh" of Medi-Cal's Rebate accounting and Information System (RAIS). The DHS states that a "refresh" is necessary for the system given its age and the importance the system provides in supporting the invoicing of over $1 billion in Medi-Cal drug rebates.

According to the DOF, prior to expenditures of funds for this project, the DHS shall provide a business-based justification of the need as well as a cost analysis for the project. The DHS states that expenditure of these funds will require DOF approval.

The DHS contends that the RAIS "production platform"—the system used to develop and test needed ongoing modifications to the RAIS production system—is near the end of its useful life period and is in need of equipment refresh.

The DHS states that memory storage is reaching its maximum capacity while hardware components are starting to fail due to age of the equipment. The Fiscal Intermediary contractor—EDS—is being directed to evaluate all production equipment used for the drug rebate program and determine which components need to be replaced within the 2005-06 fiscal year.

Background: The RAIS supports annual invoicing of over $1 billion in rebates on drugs and blood factors provided by Medi-Cal. The RAIS "production system" was implemented in 2001 and has collected over $4 billion in drug rebates. RAIS is used for invoicing drug rebates and tracking payment collections. This system was developed and is maintained by Unisys under a subcontract with EDS.

Subcommittee Staff Recommendation: It is **recommended to adopt the May Revision.**

Questions:

1. DHS, Please provide a brief summary of the request and an idea as to its timeline for completion.

22. CA Medi-Cal Management Information System—Two Issues

Issue: The DHS is requesting two changes in the May Revision for this project. **First, they are seeking to convert 5 limited-term positions (expire as of June 30, 2005) to permanent status effective July 1, 2005.**

These positions are used to maintain the Medi-Cal claims processing contract to ensure the integrity of the California Management Information System. **The May Revision proposes an increase of $490,000 ($193,000 General Fund) for this purpose. The positions are:** (1) three Associate Governmental Program Analysts, (2) one Associate Information Systems Analyst, and (3) one Nurse Consultant**. The DHS states that these five positions work as a team and that all are necessary.**

The CA Medi-Cal Management Information System (CA-MMIS) is operated by the state's Fiscal Intermediary—EDS, Inc. This contract is one of the largest ($188 million in 2004-05) and most complex contracts in state government with millions of lines of computer program coding and hundreds of computer programs required to operate the system. According to the DHS, these five requested positions have contributed to the timely implementation of new programs, helped reduce the incidence of significant system errors, installed changes to identify program fraud, and approved system changes resulting in millions of dollars in program savings.

DHS contends the positions are necessary to (1) avoid costly monetary losses resulting from the inability to perform contract management and oversight; (2) manage the design, development and installation of system changes to effectuate state budgetary proposals; (3) ensure that necessary medical services are accurately paid in a timely manner; and (4) ensure that provider claims for services are processed according to Medi-Cal policies.

Second, the DHS is requesting an increase of $500,000 ($250,000) to assess the CA-MMIS to help guide the DHS in planning the future direction of the CA-MMIS system.

The DHS states that they intend to contract for this assessment using the California Multiple Award Schedule (CMAS) contractor list from which to select a contractor.

Background—CA-MMIS: The CA-MMIS is the claims processing system used for Medi-Cal. The DHS states that over 20 years of changes to this system to incorporate technological advances as well as to address new business and legislative requirements has contributed to a system that is extremely complex.

Subcommittee Staff Recommendation: It is recommended to **(1)** approve the request to provide an increase of $490,000 ($193,000 General Fund) to permanently establish the five positions, **(2)** approve the request to provide $500,000 ($250,000 General Fund) for the assessment, and **(3)** adopt Budget Bill Language to require the DHS to provide the assessment information to the Joint Legislative Budget Committee. This proposed language is as follows:

> "Upon completion of the CA-MMIS assessment, the Department of Health Services shall provide a copy of the assessment to the Joint Legislative Budget Committee."

Questions:

1. DHS, Please provide a brief summary as to why the positions are needed.

C. Item 4260 Department of Health Services *(Others for Prop 99)*

PUBLIC HEALTH ISSUES

1. Proposition 99-Funded Programs for the Budget Year-- *Issues "A" to "D"*

(See Hand Outs—multiple charts)

Overall Background on Proposition 99: Proposition 99, the Tobacco Tax and Health Protection Act of 1988, established a surtax of 25 cents per package on cigarettes and other tobacco products, and provided a major new funding source for health education, indigent health care services, and resources programs.

Various programs, administered under several different state departments, are funded using revenues deposited in the specified accounts. The accounts that pertain to health care are as follows:

- *Hospital Services Account:* This account receives **35 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided in hospital settings.
- *Physician Services Account:* This account receives **10 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided by physicians.
- *Unallocated Account:* This account receives **25 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided by physicians.
- *Research Account:* This account receives **5 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant research activities associated with anti-tobacco efforts. This account also receives funding from Proposition 10—the California Children and Families First Act of 1998.
- *Health Education Account:* This account receives **20 percent** of the annual Proposition 99 revenues. Revenues from this account are used for various anti-tobacco education efforts. This account also receives funding from Proposition 10—the California Children and Families First Act of 1998.

Overall Governor's May Revision: The May Revision projects **increased Proposition 99 revenues** due to an increase in the revenue estimate for other tobacco products (like chewing tobacco). Total revenues are estimated to be $321 million for 2005-06.

The May Revision has changed considerably, partially in response to actions taken by this Subcommittee. **Key aspects of the Governor's May Revision proposal and its interaction with prior Subcommittee actions is outlined below:**

- *Fourth-Fifths Vote for Federal Funds:* Conforms to the Subcommittee's action to adopt legislation to amend Proposition 99 to authorize the state to use these funds to draw down federal matching funds (for example, federal S-CHIP funds, Medicaid funds or potentially, hospital Waiver funds). Only the three "indigent health care" accounts—Physician, Hospital Services, and Unallocated Accounts would be affected by this proposal.

- *Access for Infants and Mothers (AIM) Funding:* As noted in the May 9th Subcommittee hearing, agreement with the Administration has been reached regarding legislation to enable California to draw down federal funds for perinatal/pregnancy care for women provided in both the AIM Program and the Prenatal Care Services to Undocumented Women Program.

  With respect to the non-federal match for AIM, the Administration had proposed in January to use General Fund support for this purpose. **However in the May Revision, the Governor has now elected to shift to the use of Proposition 99 Funds in lieu of using General Fund support.** Use of Proposition 99 Funds is now being proposed because of the four-fifths vote legislation. **Using Proposition 99 Funds saves $27.4 million in General Fund support.**

- *Use of Managed Risk Medical Insurance Program Reserve:* As discussed in our May 9th hearing, there is $20 million in reserve in the MRMIP Fund due to the recovery of prior-year overpayments to certain health plans. The Governor's January budget had not recognized this revenue source. In his May Revision, the MRMIP retains these funds and then receives only $20 million as part of the Proposition 99 revenue transfer to them. As such, MRMIP receives their $40 million (i.e., keep reserve and receive $20 million) as historically provided. Further, this action then allows for $20 million in Proposition 99 revenues to be used in other programs.

  In the May 9th Subcommittee hearing, the Subcommittee appropriated $18 million of the $20 million in excess MRMIP reserve and used these funds to **(1)** provide $3 million to the Steven M Thompson Medically Underserved Account to address physician loans and providing services in medically underserved areas, **(2)** provide $2 million on a one-time basis to the Rural Demonstration Program in the HFP, and **(4)** backfill $13.2 million in General Fund support on a one-time basis in the CCS Program.

- *Deletes Use for Legal Immigrants in Medi-Cal and Directs to Orthopedic Hospital Settlement Funding:* The Governor's January budget had proposed using a portion of Proposition 99 funds to back fill for General Fund support in the Legal Immigrant Program within Medi-Cal. **Concerns were raised by the Subcommittee regarding this January proposed fund shift in earlier hearings. As such, the May Revision proposes to use Proposition 99 funds to backfill for a portion of General Fund support in the Orthopedic Hospital Settlement.** (This is a settlement agreement that provided for rate adjustments for hospital outpatient services. No issues remain on the settlement, the state just funds the expenditures for it. In addition, we receive a federal Medicaid match.) The May Revision recognizes the concerns that had been expressed.

- *Numerous Program Adjustments, Including New Programs:* The May Revision proposes numerous caseload and funding adjustments for programs historically funded by Proposition 99 Funds. **In addition, the May Revision proposes new funding of $4 million (Proposition 99 Funds) on a one-time basis for certain Asthma-related activities**.

- *Deletes All Proposition 99 Funding for the State Hospitals:* The May Revision deletes $20.5 million in Proposition 99 Funding that had been provided for the State Hospitals within the Department of Mental Health in the January budget.

Issue "A"—Access for Infants & Mothers Funding—*Several Issues*

Issue: The **May Revision proposes to use Proposition 99 Funds in lieu of General Fund support, as had been proposed in the Governor's January budget, for the AIM Program. This fund shift will save $27.4 million (General Fund). The proposed above Proposition 99 Fund adjustments reflect an increase of $3.3 million for caseload and then the shift from General Fund to Proposition 99 Funds.** A minor adjustment is also proposed for a federally required consumer survey (AIM and HFP).

These funds will be used as a federal match to draw down an enhanced federal S-CHIP match of 65 percent. This is now being proposed due to the four-fifths vote proposal which will enable Proposition 99 Funds to be used as a federal match (only for the three indigent health care-related accounts).

The availability of federal funds is due to federal CMS regulatory changes as was discussed in the Subcommittee's April 4th and May 9th hearings. Trailer bill language regarding this aspect of the issue has been agreed to by the Subcommittee, Administration and other involved parties.

Specifically, the May Revision proposes total expenditures of $115.7 million ($50.7 million Perinatal Insurance Fund—receives transfers from Proposition 99 accounts--, $1.1 million General Fund, and $63.9 million federal S-CHIP funds) to provide pregnancy, delivery, postpartum care and other comprehensive health care services to 10,581 women, 8,421 first-year infants and 75,288 second-year infants.

The May Revision provides a total of $44.6 million in Proposition 99 Funds for AIM that are transferred to the Perinatal Insurance Fund for expenditure. The Proposition 99 Funds are as follows:

- Provides $34.4 million from the Hospital Services Account;
- Provides $10 million from the Physicians Services Account; and
- $175,000 for a consumer survey for the AIM/HFP programs (the survey is required by federal law).

The proposed above Proposition 99 Fund adjustments reflect an increase of $3.3 million for caseload and then the shift from General Fund to Proposition 99 Funds.

In addition, the May Revision proposes an increase of $6.4 million ($2.2 million General Fund and $4.1 million federal S-CHIP funds) to reflect an average 7.2 percent rate increase for pregnant women, and an average 1.6 percent rate increase for infants up to one year of age, and an average 3.9 percent rate increase for infants from one year to two years of age. This is based on recently completed contract negotiations with the MRMIB and the participating Health Plans. This issue had been

referenced in a prior Subcommittee hearing but dollar amounts were not at that time available.

Background—AIM Program: The Access for Infants and Mothers (AIM) Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level. Subscribers pay premiums equal to 2 percent of the family's annual income plus $100 for the infant's second year of coverage.

Subcommittee Staff Recommendation: It is **recommended to adopt the May Revision appropriation amounts for AIM as proposed by the Administration**. No issues have been raised.

The Subcommittee's actions regarding trailer bill language adopted in prior hearings remain in tact (i.e., language regarding S-CHIP and receipt of federal funding, and the four-fifth's vote language change to Proposition 99 to allow for a federal match).

Questions:

1. MRMIB, Please provide a brief summary of the budget proposal.

Issue "B"—Managed Risk Medical Insurance Program (MRMIP) & All Related Interactions with Prior Subcommittee Actions

Issue: The May Revision proposes to require the Managed Risk Medical Insurance Board to fund the MRMIP Program at its capped appropriation amount of $40 million by **(1)** using the existing $20 million in MRMIP reserve funds, *and* **(2)** obtaining only a $20 million transfer from Proposition 99 Funds. Normally there would have been a $40 million transfer to this MRMIP from Proposition 99 Fund accounts. No other changes to the program are proposed.

This proposed May Revision action requires technical trailer bill language, which adjusts existing statute, for the $20 million transfer (in lieu of the standard $40 million transfer). This language is as follows:

> "Notwithstanding Section 12739 of the Insurance Code, on a one-time basis for the 2005-06 budget year, upon order of the Director of Finance, the State Controller shall reduce the amounts to be deposited in the Major Risk Medical Insurance Fund as follows: $3,107,000 reduction from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund; $5,893,000 reduction from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund; and $1,000,000 reduction from the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund."

Prior Subcommittee Hearing: In the May 9th hearing, the Subcommittee adopted the following actions (all actions are Proposition 99 Funds):

- Appropriated **$18.2 million** of the $20 reserve in the MRMIP available from the adjustments to health plans from past years **and allocated these funds as follows**;
    - **$3 million** (one-time only) to the **Steven M. Thompson Medically Underserved Account** to address physician loans and providing services in medically underserved areas.
    - $2 million (one-time only) to **the Rural Demonstration Projects in the Healthy Families Program.**
    - **$13.2 million (one-time) to backfill for General Fund support in the California Children Services Program (CCS.** Budget Bill Language was also done to clarify the intent of this action.

Subcommittee Staff Recommendation (See Table, below): **It is recommended to:**

(1) Adopt the May Revision for the MRMIP, including the trailer bill language;

(2) Retain the $3 million transfer for the Steven M. Thompson Medically Underserved Account by appropriating $2 million from the Physicians Services Account and $1 million from the Unallocated Account of Proposition 99;

(3) Reduce by $2 million (Physicians Services Account) in the California Healthcare for Indigent Persons Program (CHIPP);

(4) Reduce by $1 million (Unallocated Account) the new proposal for Asthma activities.

(4) Reduce by $1 million (Unallocated Account) the Media Campaign;

(5) Provide $1 million (Unallocated Account) for the Rural Demonstration Projects, in lieu of the $2 million (Proposition 99 Funds) prior Subcommittee action and increase by $1.9 million (federal S-CHIP funds) to recognize the match to these funds; and

This information is shown in the Table below.

Program (Proposition 99 Funds)	Governor's Budget	Governor's May Revision	Governor's Change	Staff Recommended Adjustment to May Revision
CHIP Program	$45,252,000	$68,236,000	$22,984,000	-$2,000,000 ($66,236,000)
Media Campaign	$15,695,000	$1,000,000 (Unallocated Acct)	$16,695,000	-$1,000,000 ($15,695,000)
Asthma	N/A	$4,000,000	$4,000,000	-$1,000,000 ($3,000,000)
Subtotal Adjustment			N/A	**-4,000,000**
Steven M. Thompson				+$3,000,000
Rural Demonstration	$1,047,000	$1,047,000	no change	+$1,000,000 ($2,047,000)
Subtotal Adjustment			N/A	**+4,000,000**

Background on Steven M. Thompson Program: The Steven M. Thompson Physician Corps Loan Repayment Program, operated by the Medical Board of California, is used to repay student loans for physicians and surgeons practicing in medically underserved communities.

Existing law creates the Medically Underserved Account for the purposes of the program. The fund consists of private donations and transfers from the Contingent Fund of the Medical Board which is supported by fees. The total amount of the transfers from the Contingent Fund to the Medically Underserved Account is $3.450 million ($1.150 million annually for three consecutive years which began in 2003). As such, the last transfer occurs in 2005-06.

Background—Description of the Rural Demonstration Projects in the HFP: The Rural Demonstration Projects within the Healthy Families Program (HFP) have been operational since the inception of the HFP. These projects have used different strategies, contingent on the rural area's needs, for addressing barriers faced by residents of rural areas in receiving health care. Examples have included (1) purchasing dental equipment; (2) improving patient tracking systems; (3) extending clinic hours during certain seasons; (4) establishing telemedicine capabilities; and (5) improving coordination with local drug and alcohol providers.

Background on CHIP Program: The May Revision proposed an increase of $22.9 million from the January budget for the California Healthcare for Indigent Persons

Program. Specifically, the proposed appropriation went from $45.3 million to a proposed $68.2 million. Funds in this program assist in funding uncompensated medical care needs.

Background on the New Asthma Activities: The **Administration proposes to use $4** million in new one-time only Unallocated Account Funds to conduct surveillance of asthma prevalence, hospitalizations, mortality, and risk factors, to refine the most appropriate prevention strategies. The DHS will also conduct the Childhood Asthma Initiative addressing asthma in children aged 0 to 5 years, and the California Asthma Among the School Aged program addressing asthma in children aged 5 to 18 years. The programs will fund asthma community health worker services in 20-35 community health centers statewide, and provide asthma training and materials will be provided.

It should be noted that these funds are being used as a replacement for foundation funding and funds provided by the California Families First Commission (Proposition 10 Funding). It should also be noted that based on the Administration's May Revision proposal, about $754,000 of "unrestricted reserve" funds are available for expenditure in the Health Education Account. If necessary, the Administration could choose to use a portion of these funds to support Asthma education material development as it pertains.

Background Media Campaign: The Governor's budget proposed $15.7 million (Health Education Account Funds) for the annual media campaign regarding anti-smoking messages. His May Revision augments by $1 million from the Unallocated Account which is historically used to fund indigent health care programs. Among other things, the augmentation would be used to (1) provide $200,000 to contract for improvements to the DHS online tobacco information system, (2) $200,000 to contract for the design and implementation of an updated evaluation method for the DHS staff to use for the "local competitive grants" (This is a separate program that will receive $18.4 million in funds), (3) and increase anti-smoking messages.

Issue "C"—Emergency Physicians Use of Proposition 99 Funds

Issue: For the past five years, the Legislature has been appropriating ***about*** **$25 million** (Proposition 99 Funds) annually to reimburse emergency and on-call physicians for the costs of providing care to uninsured, indigent patients requiring emergency medical care. **The Governor's May Revision continues this appropriation level.**

It has come to the attention of interested parties and Subcommittee staff that since a 4/5ths vote to allow Proposition 99 Funds to be matched with federal funds is being pursed by both the Subcommittee and now the Administration, these funds should be used within the Medi-Cal Program to obtain a federal match. **This option is shown in the Subcommittee staff recommendation below.**

Prior Subcommittee Action: In the May 9th hearing, the Subcommittee took the following actions:

- Appropriated $24.8 million (Proposition 99 Funds) as proposed by the Administration;
- Deleted the Administration's Budget Bill Language (unnecessary due to trailer language);
- Adopted trailer bill language that more specifically states how emergency physicians would be reimbursed using these funds;

Subcommittee Staff Recommendation: It is **recommended to rescind the prior Subcommittee action and to instead (1)** appropriate the $24.8 million (Proposition 99 Funds) under the Medi-Cal Program, local assistance item, **(2)** increase federal funds by $24.8 million to reflect the matching rate, and **(3)** adopt trailer bill legislation to provide for a **Medi-Cal rate increase of 62 percent for emergency physicians who provide services in an emergency room or trauma care facility.**

The rate increase percentage assumes that a total o $79.1 million ($24.8 million Proposition 99 Funds and a federal match) would be available. Based on DHS data as provided to the Subcommittee as a technical assistance request, six of the HCPCS procedure codes account for the bulk of the expenditure for services in an emergency room setting

According to technical assistance provided by the DHS, a standard State Plan Amendment would be needed for final approval but this should be straightforward.

Questions:

1. DHS, Please provide technical assistance comments, if necessary regarding the recommendation.

Issue "D"—Other May Revision Adjustments *(See Hand Out)*

Issue: The May Revision for Proposition 99 Funded-Programs also makes a number of other adjustments as follows:

- ***Deletes Use for Legal Immigrants in Medi-Cal and Directs to Orthopedic Hospital Settlement Funding:*** The Governor's January budget had proposed using a portion of Proposition 99 funds to back fill for General Fund support in the Legal Immigrant Program within Medi-Cal. Concerns were raised by the Subcommittee regarding this January proposed fund shift in earlier hearings. As such, the May Revision proposes to use Proposition 99 funds to backfill for a portion of General Fund support in the Orthopedic Hospital Settlement**.** (This is a settlement agreement that provided for rate adjustments for hospital outpatient services. No issues remain on the settlement, the state just funds the expenditures for it. In addition, we receive a federal Medicaid match.) The May Revision also backfills with General Fund support in the Legal Immigrant Program in Medi-Cal. (This adjustment is in the Medi-Cal local assistance baseline).

- ***Breast Cancer Early Detection Program (Every Woman Counts):*** An increase of $1.139 million to support increased case load.

- ***Competitive Action Grants:*** An increase of $3.6 million is provided for the Tobacco Control Section's Competitive Grant Program. This program funds a variety of local, regional, statewide and pilot projects that seek to educate people about the dangers of tobacco use.

- ***Evaluation for Competitive Action Grants:*** Increases by $400,000 to allow the DHS to evaluate the competitive grant programs and projects.

Subcommittee Staff Recommendation: It is recommended to adopt the May Revision for these items and the remaining base amounts. No issues have been raised.

Questions:

1. DHS, Please provide a brief summary.

2. West Nile Virus

Issue: The May Revision proposes an increase of $12 million (General Fund) and two pieces of Budget Bill Language, which among other things, allows for exemptions from the competitive bid process.

The DHS proposes to do the following with the $12 million General Fund augmentation:

- **$2 million** to purchase mosquito control products and application equipment needed throughout the state.

  Specifically, $1.7 million of this $2 million amount will be for the purchase of mosquito control products and application equipment, $140,000 is for administrative oversight through contract services, and $120,000 is for auditing local agencies.
- **$3 million** for emergency mosquito control response in West Nile "hot spots". These funds will be distributed to "high risk" counties and potentially under-funded agencies from the southern region of the state;
- **$2 million** to the Northern Sacramento Valley, especially the Butte Sink area (i.e., Butte, Colusa, Glenn, and Sutter counties);
- **$1.5 million** to the Northern San Joaquin Valley;
- **$2 million** to the Southern San Joaquin Valley; and
- **$1.5 million** to the Sacramento Delta region.

According to the DHS, the $10 million in local assistance would be provided through allocation agreements to supplement resources for existing mosquito control programs and for expansion to surrounding areas.

The DHS is also seeking approval of the following two pieces of Budget Bill Language:

Provision x for the $2 million (Item 4260-001-0001):
"In response to the public health implications of the West Nile Virus, and in order to expedite the implementation of mosquito control efforts funded by no more than $2 million appropriated in this item, the department shall be exempt form competitive bidding, and shall be exempt from the requirements of Part (commencing with Section 10100) of Division 2 of the Public Contract Code for purposes of making and receiving and/or entering into contracts and interagency agreements."

Provision x for the $10 million (Item 4260-111-0001):
"(a) Of the amount appropriated in this item, the department shall at the discretion of the Director allocate $10 million to local mosquito and vector control agencies or other governmental entities, or contract with other entities to supplement resources for existing local mosquito control programs or to provide mosquito control efforts to currently unserved areas across the state in response to the threat of West Nile Virus transmission.

(b) In response to the public health implications of the West Nile Virus, and in order to expedite the implementation of mosquito control efforts funded by no more than $10 million dollars appropriated in this item, the department may make and receive grants, and enter into contracts and interagency agreements, shall be exempt from competitive bidding, and shall be exempt from the requirements of Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code."

Background—Current Efforts: According to the DHS, **about $70 million is budgeted by local mosquito control districts**. In a recent survey by the DHS, local mosquito control agencies reported that expenditures (dollars per parcel) for mosquito control agencies increased 16.1 percent from 2003 to 2005 resulting in elimination of emergency mosquito treatment funding reserves in many districts.

In addition, the Legislature appropriated $977,000 (General Fund) to the DHS to support West Nile Virus activities. These funds allow for (1) expanded surveillance activities to enhance detection, (2) improved laboratory diagnostic methods and capabilities, and (4) enhanced efforts to educate the general public, affected industries, medical and veterinary health communities and others.

Subcommittee Staff Recommendation: It is recommended **to approve as proposed in the May Revision.**

Questions:

1. DHS, Please provide a brief summary of the request, including how quickly the funds will be provided to the local entities.

3. Proposal to Use Federal Bioterrorism Funds for Capital Outlay

Issue: The May Revision proposes an increase of $1.266 million (federal Bioterrorism Funds) for preliminary plans, working drawings and construction of an Emergency Operations Center within the Emergency Preparedness Office of the DHS.

According to the DHS, the existing Emergency Operations Center operated by the DHS is presently located in inadequate space per federal guidelines and needs to be relocated to space adequate to allow the DHS to managed public health emergencies that occur within California. The proposed new Emergency Operations Center would be located within the Sacramento East End Project.

The DHS states that the federal Centers for Disease Control recently reported numerous deficiencies with the existing Emergency Operations Center including insufficient number of computer terminals, no redundant power supply or communication ability, and an inability to ensure 24-hour-a-day coverage.

The DHS states that during a disaster, an additional 40 specialists could be working at the Emergency Operations Center. They contend that the typical Emergency Operations Center allows for easy managerial observation of emergency workers, planning areas, conference areas, redundant communications capabilities, and backup electrical power.

The proposed Emergency Operations Center would occupy a redesigned area of the third floor of Building 173 at the East End Project. Enhancements would include modular furniture removal, and redesign with some new components to be purchased, management and planning rooms, communications, logistics, supply storage room creased from an existing conference room, and a breakout room for small teams created from a quite room.

Renovations include new walls, glazing and blinds, new and relocated doors and hardware, blackout window shades, new and relocated lighting, mechanical, electrical outlets, telecommunication/data outlets and audio/visual infrastructure. All electrical including the lighting and HVAC for this space will be put on emergency generator power. New low height antennas and satellite dishes will allow for a fully functional Emergency Operations Center.

The space adjacent to the Emergency Operations Center will have three new quite rooms, seven new offices and a new copy room. Renovations are needed on all of this as well.

Subcommittee Staff Recommendation: It is suggested to take this issue to Conference in order to obtain more information regarding whether all of this proposed work can be completed using the proposed $1.266 million. It is highly usually to receive a request for Capital Outlay in the May Revision.

Capital Outlay letters are customarily provided to the Legislature by May 1st in order to provide for an appropriate review period. In addition, confirmation needs to be received from the federal CDC that federal bioterrorism funds can be used for this purpose.

Questions:

1. DHS, Have you officially received written confirmation that the federal bioterrorism funds can be used for construction purposes?
2. DHS, Will the proposed $1.266 million fully fund the entire project as proposed?
3. DHS are any other costs likely to be incurred from this project, such as moving costs or other support items? If so, how much?

4. Administration's Proposal on Mitigating Obesity—"Better State of Health" (See Hand Outs)

Issue: The budget proposes **an increase of $ 6 million (General Fund)** for an obesity prevention program. Of this amount, $3 million is for state support including two new positions and consultant contacts, and $3 million is for local assistance.

The Administration is also proposing trailer bill legislation to create the program and to award contracts. The language contains a two-year sunset clause.

Summary Table of Administration's Proposal

DHS Component	DHS Positions	General Fund Expenditure
DHS Coordinating Office	**1**	$ 371,000
Training & Technical Assistance		500,000
Surveillance, Evaluation & Research		500,000
Public Relations		150,000
Operating Expenses		76,000
Subtotal		($1,597,000)
Enhance Medi-Cal Services		1,408,000
Community Action Grants	**1**	3,029,000
TOTALS	**2**	**$6,034,000**

Under the proposal, **a "coordinating office"** would be created and would report directly to the State Public Health Officer. This new office would serve as the lead entity within the DHS to facilitate all public health obesity prevention initiatives. **It is estimated that $371,000 would be expended for this coordinating office**.

Of the proposed $6 million total, about $2.8 million would be used for various consultant contracts as follows:

- $150,000 for public relations;
- $500,000 for clearinghouse information and training;
- $500,000 for surveillance, applied research and evaluation activities;
- $150,000 for DHS work place wellness; and
- $1.4 million for quality improvement techniques in up to six participating health plans in Medi-Cal. The techniques would include promotion of breastfeeding, increased screening to promote healthy eating, and treatment and referral for overweight and at-risk for overweight children. The project would be implemented in up to six collaboratives made up of hospitals, clinics, and other medical service providers that serve significant numbers of Medi-Cal beneficiaries

The $3 million proposed for local assistance would be allocated to 15 new **and existing** "community action projects". The intent of these projects would be to address both nutrition and physical activity issues in local communities and serve as role models for the state.

***Background on Existing Programs (See Hand Outs)*: Currently, DHS spends about $1.2 billion annually** from federal and private sources for a variety of programs that are intended to promote good nutrition and increased physical activity as a means to improve public health. Approximately 75 percent of the funding is for the Women, Infants, and Children (WIC) Program. WIC provides nutritional education, breastfeeding information and of course, nutritional food to low-income families.

Numerous programs reside within the DHS that address issues regarding nutrition, the promotion of physical activity and healthy eating behaviors, and reach activities, such as the following (selected examples):

- **$895 million (federal funds) in WIC**. This amount is used to provide nutritious foods to a specific population as a short-term intervention and adjunct to on-going health care. Foods are selected to meet enhanced dietary needs.

- **$212.6 million (federal funds) in WIC.** This amount is to provide education to pregnant women and parents to support healthy pregnancy outcomes, successful breastfeeding, and promoting active lifestyles for children.

- **$3.3 million (federal funds) in WIC Farmer's Market.** This amount provides fresh fruits and vegetables to WIC participants.

- **$90 million (federal funds) for the CA Nutrition Network for Healthy, Active Families (Network).** The Network is funded primarily by federal funds awarded by the USDA. The six key strategic result areas that the Network employs to secure large-scale behavior change among low-income families are as follows:
    - Provide statewide leadership, build infrastructure and mobilize resources for large-scale social marketing campaigns to promote healthy eating, physical activity, and food security to help prevent serious chronic diseases such as cancer, diabetes, heart disease and obesity;
    - Conduct media and retail promotions;
    - Conduct surveys, research and evaluation;
    - Develop and empower lower-income communities;
    - Conduct special programs for children; and
    - Stimulate and enable changes in policies, systems, and environments to make healthy eating and physical activity easiest choices for lower-income families.

- **$1.7 million for CA Project LEAN** (federal funds) to increase access to healthy foods and physical activity.

- **$1.3 million for CA Center for Physical Activity** to increase physical activity level to reduce chronic disease.

- **$275,000 for the CA Obesity Prevention Initiative** to reduce the burden of obesity and to support obesity prevention. They are to also do strategic planning on obesity in California.

- **$284,000 (Title V Funds)** to provide assistance to local maternal and child health programs to improve nutrition within the maternal and child health population.

Legislative Analyst's Office Comment & Recommendation: The LAO raises a number of concerns with the proposal, including the overlap with many existing activities. **Given the multitude of programs, projects and activities at the state level, the LAO urges the Administration to complete an assessment of the nutrition programs that are currently functioning before additional General Fund resources for new obesity prevention efforts are committed.**

The LAO recommends approving only $180,000 (General Fund) of the $6 million to fund a Medical Officer position. This position would be used to direct the department's coordinating activities. The remaining amount—about $5.9 million—would be deleted from the request.

Subcommittee Staff Recommendation: Subcommittee staff concurs with the LAO analysis to provide $180,000 to fund the Medical Officer position to conduct coordinating functions or redesign activities regarding the state's nutritional programs. **This action would conform to the Assembly.**

In addition, it is recommended to adopt Budget Bill Language as follows (4260-001-0001):

"The DHS shall develop a comprehensive strategic plan that would assess California's current programs and efforts in obesity prevention, identify core gaps or concerns, identify best practices and make recommendations for improvement. This strategic plan shall be provided to the Legislature when completed, but by no later than June 30, 2006."

Finally, due to the state's fiscal crisis, question arises as to why the Administration's obesity-related health care concerns cannot be addressed through other means. For example, The California Endowment (TCE) is presently investing $26 million for a variety of efforts, including $9 million to five communities over a four-year period to combat childhood obesity. Further, there are other non-General Fund resources that could be made available, such as funds from the Families First Commission (Proposition 10). In addition, several foundations are approving projects in this area.

Questions:

1. DHS, Please provide an overview of your proposal.
2. DHS, How does this new proposal interact with the $1.2 billion in existing program resources in this area and how is it different?

D. Item 4440 Department of Mental Health (*Discussion Items*)

Community Mental Health Issues

1. Mental Health Managed Care—May Revision Adjustments

Issues: The May Revision proposes a net reduction of $974,000 (General Fund) to the Mental Health Managed Care Program. This net reduction reflects the following adjustments:

- Decrease of $1.047 million for a change in the number of Medi-Cal eligibles.
- Increase of $9,000 to reflect a one-percent adjustment for inpatient growth.
- Reduction of $3,000 for a decrease in the number of eligibles in the Breast and Cervical Cancer Treatment Program who obtain mental health assistance.
- Increase of $67,000 to reflect changes in the appeals and state fair hearing processes. The federal CMS, as a condition of approving California's Waiver renewal for Mental Health Managed Care, required some modifications to this process. Effective under the Waiver renewal, enrollees must exhaust the problem resolution process before going to a state fair hearing. The DMH states that this change will result in costs related to training, informing materials, revised notices of action and regulations.

California received federal CMS approval of the state's Waiver renewal as of April 26, 2005, only one day shy of its expiration date of April 27th (after one extension).

Background—Overview of Mental Health Managed Care: Under Medi-Cal Mental Health Managed Care psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, became the responsibility of a single entity, the Mental Health Plan (MHP) in each county.

Full consolidation was completed in June 1998. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government. Medi-Cal recipients *must* obtain their mental health services through the County MHP.

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements.

Background—How Mental Health Managed Care is Funded: Under this model, County MHPs generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. County MHPs access County Realignment Funds (Mental Health Subaccount) for this purpose.

An annual state General Fund allocation is also provided to the County MHP's. The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included, changes in the number of eligibles served, and when funding is provided, factors pertaining to changes to the consumer price index (CPI) for medical services.

The state's allocation is contingent upon appropriation through the annual Budget Act.

Subcommittee Staff Comment and Recommendation: It is **recommended to adopt the** May Revision. No issues have been raised with the estimate.

Questions:

1. DMH, Please provide a brief summary of the May Revision, including the requested federal CMS change to the state's fair hearing process.

2. Federal CMS Requirement Regarding "Informing Materials"

Issue: The May Revision proposes a special one-time only increase of $19.3 million ($9.6 million General Fund) imposed by the federal CMS on California as a condition of approving California's Waiver for Mental Health Managed Care.

The proposed expenditures include the costs of printing and mailing to 3.5 million households of existing Medi-Cal enrollees, as well as tens of thousands of new enrollees in the program, 60-page brochures on mental health program benefits and extensive lists of providers of mental health services. For example, the DMH proposes to mail every Medi-Cal household in Los Angeles County a 976-page list of providers as well as the 60-page brochure.

On March 11, 2005, the federal CMS, DMH and DHS (sole Medicaid state agency role) participated in a conference call to discuss the Waiver renewal request. During this conference call, the federal CMS indicated that they intended to deny California's request for a waiver of the provision of federal law that requires state's to meet certain "informing" requirements.

As a result of this denial, the DMH must comply with the federal requirement to provide a one-time distribution of informing materials to all Medi-Cal enrollees in each county and a one-time distribution of informing materials and provider lists to all current mental health clients. The DMH had originally requested to comply with this federal requirement by providing informing materials and provider lists to enrollees when they first access services through the County Mental Health Plan, *and* on request of the enrollee at any time. However, the federal CMS did not find this to be acceptable.

The DMH therefore contends that the denial of California's request by the federal CMS results in the proposed expenditures.

Legislative Analyst's Office Recommendation: The LAO recommends to reduce the request by $4.4 million ($2.2 million General Fund) by having the DMH mail out three or more regional versions of the provider directory within Los Angeles County, instead of one single 976-page directory as proposed. This action would reduce printing and mailing costs of complying with federal rules.

In addition, the LAO recommends adopting Budget Bill Language directing the DMH to expend no funding for these purposes until October 1, 2005, in order to provide the state with additional time to seek relief from the federal CMS for these excessive federal mandates. The proposed Budget Bill Language is as follows:

> "None of the funds appropriated in this item for compliance with federal Medicaid managed care notification requirements shall be expended before October 1, 2005. It is the intent of the Legislature that, in the interim, the state shall seek assistance from the California congressional delegation, the new national commission to reduce Medicaid Program costs, or other appropriate parties to modify these requirements to reduce their cost to the state and to the federal government. In the event that the federal notification requirements are modified, the Director of Finance may revert, at his discretion, any part or all of the appropriation provided in this item for compliance with the requirements."

Subcommittee Staff Recommendation: The DMH, LAO and Subcommittee staff believes that the federal CMS is being very unreasonable with respect to these requirements. The requirements are excessive and will likely be of no use to the Medi-Cal enrollee. Further for those individuals who will also be enrolling into the Medicare Part D program, any huge mailing could lead to further confusion. However, until California can make the federal CMS bend towards being practical, the requirement must be addressed or the federal CMS could rescind their approval of California's Waiver.

It is therefore recommended to adopt the LAO recommendation to **(1)** reduce by $4.4 million ($2.2 million General Fund), and **(2)** adopt Budget Bill Language as proposed.

Questions:

1. DMH, Please explain the requested augmentation and any rationale behind the federal CMS demands.
2. DMH, Please comment on the LAO recommendation.

3. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Issue: The May Revision proposes two adjustments for the EPSDT Program. **First,** the Administration is requesting an increase of $139.4 million ($67.7 million General Fund) to pay County Mental Health Plans for the final settlement of fiscal year 2002-03 cost reports under the program. **Second**, a decrease of $117.9 million ($55.7 million General Fund) is proposed for 2005-06. Both of these proposed changes are based on updated projections for EPSDT children's mental health services program costs.

Legislative Analyst's Office Recommendation: The LAO is recommending a technical adjustment to reduce the May Revision request by a total of $11.8 million (Reimbursements which are **$4.996 million in state General Fund**) to account for anticipated savings on program costs from new auditing activities that will commence in the current fiscal year (2004-05). This adjustment is the total amount across the two-year period (i.e., reduction of $1.665 million General Fund in 2004-05 and a reduction of $3.331 million in 2005-06)

The DMH's January budget had reflected savings in 2005-06 from these audits but it appears that this adjustment was inadvertently left out of the May Revision calculation.

Subcommittee Staff Recommendation: It is recommended to adopt the LAO recommendation to reduce by $11.842 million ($4.996 million General Fund), pending any further technical change by the DMH.

Questions:

1. DMH, Please provide a brief summary of the EPSDT proposal.
2. DMH, Do you concur with the LAO adjustment to account for the savings from auditing claims?

4. Mental Health Services Provided to Special Education Students ("AB 3632")

Issues: The May Revision proposes changes to the Governor's January proposal regarding this program. Based on these recent changes, the following key aspects to the program should be noted:

- ***Education:*** Continues **$100 million in funding** for mental health services. Of this amount, $69 million (federal IDEA funds) is set-aside for County Offices of Education to contract with counties for service provision.

  The remaining $31 million (Proposition 98/General Fund) is provided directly to Local Education Agency.

- ***Department of Mental Health and State Controller:*** Provides **$90 million** (General Fund) to reimbursement County Mental Health for a portion of the costs claimed for the mandates for fiscal years 2002-03, 2003-04 and 2004-05. Specifically, $72 million is to reimburse auditable claims for the "Services to Handicapped Students Program, and $18 million is for reimbursement of auditable claims for the Seriously Emotionally Disturbed Pupils Program.

- ***Repeals Statute:*** Administration is proposing trailer bill language to repeal the relevant sections of Government Code that create the state mandates on the Counties. The proposed language would also amend SB 1895 (Burton) to ensure that special education pupils continue to have access to mental health services (according to the Administration anyway). LEAs would be allowed to contract with Counties to provide services.

  The DOF states that there is no proposal to remove the two County mandates from the schedule of programs listed in the DMH Item (4440-295-0001) or to remove the suspension language from that item until such time as the mandates are repealed.

Recent Background on the Program—No Mandate Funding and SB 1985: *Prior* to the Budget Act of 2002, County MHPs were primarily reimbursed for their AB 3632 mental health services provided to special education students through the Commission on State Mandates. However a moratorium was placed on mandate reimbursements for local government beginning in 2002. This moratorium was continued in the Budget Act of 2003. But $69 million in federal IDEA funds was appropriated to schools in the Budget Act of 2003. These funds were then to be allocated to County MHPs for their services. However, the County MHPs note that about $120 million was actually expended on AB 3632 services for this year. SB 1895 (Burton), as discussed below, clarified the funding stream interactions for the 2004-05 fiscal year.

Among other things, SB 1895 (Burton), Statutes of 2004 does the following:

- Requires LEAs, prior to the referral of a pupil to County MHPs, to follow procedures regarding an Individualized Education Plan (IEP), as defined in

current law. It also directs the LEAs to request the participation of County MHPs in this process.

- Reconfirms that County MHPs are eligible for reimbursement from the state for all allowable costs for specified mental health services provided to special education students.
- Requires that $31 million (Proposition 98/General Fund) appropriated in the Budget Act of 2004 be distributed on the basis of provided services that are consistent with the federal IDEA. The intent is that the provision of upfront, more preventive services would over time lower the costs to counties for the mandate.
- Requires that the $69 million provided in the Budget Act of 2004 allocated to County Offices of Education be used to support mental health services by County MHPs for special education children. (This offsets General Fund mandate costs.)
- Specifies that a County MHP does not have fiscal or legal responsibility for any costs it incurs prior to the approval of an IEP, except for costs associated with conducting a mental health assessment.

Background—Mental Health Services to Special Education Pupils: Federal law (PL 94-142 of 1975-- the Education for All Handicapped Children Act—and the later Individuals with Disabilities Education Act (IDEA) mandates states to provide services to children enrolled in special education, including all related services as required to benefit from a free and appropriate education. Related services include mental health services, occupational and physical therapy and residential placement.

In California, County MHPs are responsible for providing mental health services to students when required in the pupil's Individualized Education Program (IEP). This is because AB 3632 (W. Brown), Statutes of 1984, shifted responsibility for providing these services from School Districts and transferred them to the counties. This was done because School Districts were not appropriately providing the services.
These services are an entitlement and children can receive services irrespective of their parent's income-level. In addition, County MHPs cannot charge families for these services because the children are entitled to a free and appropriate public education under federal law.

What Mental Health Services Are Mandated: Services to be provided, including initiation of service, duration and frequency of service, are included on the student's IEP and must be provided as indicated. Services can only be discontinued on the recommendation of the County MHP *and* the approval of the IEP team, or by parental decision. Among other things, mental health services include assessments, and all or a combination of individual therapy, family therapy, group therapy, day treatment, medication monitoring and prescribing, case management, and residential treatment.

Subcommittee Staff Recommendation: It is recommended to **(1) reject** the Administration's trailer bill language to repeal sections of Government Code that create the mandate on the counties and modifies SB 1895 (Burton), Statutes of 2004, **(2)** reject the Administration's proposed Budget Bill Language to use funds for past mandate claims, **(3)** appropriate $90 million (General Fund)—the same amount as contained in the May Revision--, *and* **(4)** adopt Budget Bill Language as stated below.

Proposed Budget Bill Language (Item 4440-105-0001):

1. The $90 million (General Fund) appropriated in this Item shall be used to reimburse local government agencies for costs claimed for 2004-05 and 2005-06 for Services to Handicapped Students (Chapter 1747, Statutes of 1984) and Serious Emotionally Disturbed Pupils (Chapter 654, Statutes of 1996) state-mandated local programs. Reimbursement for claims shall only be made for claims that are still subject to audit by the State Controller.

2. It is the intent of the Legislature for these funds, as well as those appropriated within the State Department of Education for services to students enrolled in special education and requiring mental health assistance in order to benefit from the education services provided, to be fully expended to address needs in the 2004-05 and 2005-06 fiscal years.

SB 1895 was only enacted last year and needs to be given sometime to work. Proposition 63 Funds, which really will not begin to flow until later this year and next, can be used to assist in mitigating children needing the more intensive treatment therapies that are often needed for AB 3632-eligible children. The primary issue is to ensure that children receive timely and appropriate mental health treatment assistance. County Mental Health Plans and their contractors do this best. This is why the program was transferred in the first place in 1984.

Utilizing the budget funds in this manner will provide a total of about $145 million for 2004-05 and for 2005-06. This should equate to about full funding at this point in time.

5. Governor's Initiative on Chronic Homelessness—Proposition 63

Issue: The May Revision proposes an increase of $2.3 million *one-time only* Proposition 63 Funds—state support-- for rent subsidies and to establish collaboratives at local level to assist counties in developing projects to promote stable housing for homeless persons. Of the $2.3 million amount, $2 million is for the subsides and $400,000 is for the local collaboratives. (It should be noted that $100,000 in Proposition 63 Funds has been used in the current-year for beginning this project.)

Budget Bill Language is also proposed. This language would provide for a two-year expenditure period.

Overall, the Governor's Initiative on Chronic Homelessness consists of five core components across several departments as follows:

- $40 million (Proposition 46 Bond Funds) for housing construction for individuals with mental illness (Housing and Community Development Department). These funds will be leveraged to attract private investor capital and locality funding.
- $10 million for capital for community-based organizations (CA Housing Finance Agency).
- **$2.4 million (Proposition 63 Funds) for rent subsidies and local collaborations (Department of Mental Health)**.
- $250,000 (General Fund) to create an interagency council on homelessness to improve coordination among state departments (Business, Transportation and Housing Agency and others).
- **$750,000 (General Fund) for predevelopment loans to fund upfront housing project costs. These are the types of costs that are not eligible for bond expenditures** (Housing and Community Development Department—HCDD).

Legislative Analyst's Office Recommendation: In an effort to offset General Fund support, the **LAO is recommending to appropriate $750,000 in Proposition 63 Funds for the predevelopment loans to fund upfront housing project costs.** The $750,000 in Proposition 63 Funds would be from the state's portion of funding. Therefore, the Budget Bill Language proposed by the Administration would be modified as follows:

"Of the funds appropriated in this item, ~~$2,400,000~~ **$3,150,000** is one-time funding for rent subsides, **predevelopment costs for housing for the mentally ill**, and collaborative efforts to promote stable housing for homeless persons. These funds will be used for the Governor's Initiative to End Chronic Homelessness. These funds are available for expenditure in 2005-06 and 2006-07."

Subcommittee Staff Recommendation: It is **recommended to adopt the LAO** recommendation to **(1)** appropriate $3.150 million, and **(2)** adopt the Budget Bill Language as crafted.

Questions:

1. DMH, Please provide a brief summary of the May Revision proposal.

D. Item 4440 Department of Mental Health *(Continued Discussion Items)*

STATE HOSPITAL ISSUES

Overall Background—Summary of State Hospital Patients & Funding: The department directly administers the operation of five State Hospitals—Atascadero, Metropolitan, Napa, Patton, and Coalinga (to be activated). In addition, the DMH administers acute psychiatric programs at the California Medical Facility in Vacaville, and the Salinas Valley State Prison.

Patients admitted to the State Hospitals are generally either (1) civilly committed, or (2) judicially committed. As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans (County MHPs) contract with the state to purchase beds. County MHPs reimburse the state for these beds using County Realignment Funds (Mental Health Subaccount). Judicially committed patients are treated solely using state General Fund support.

1. State Hospital Adjustments for May Revision

Issues: The May Revision proposes several adjustments for the State Hospitals for a *net* increase of $47.8 million (increase of $128.6 million General Fund). Total expenditures for the State Hospitals are now estimated to be $888.6 million ($802.1 million General Fund) for 2005-06.

The key adjustments include the following:

- **$20.5 million reduction in Proposition 99 Funds and a corresponding increase of $20.5 million in General Fund support to backfill the loss.** (This was referenced in the Proposition 99 Fund discussion under the DHS Item.)
- **$9.2 million (General Fund) increase due to the Administration's rescission of their Sexually Violent Predator (SVP) "pre-commitment" proposal**. The identified savings came by shifting "pre-commitment" SVPs to the counties. This proposal had been rejected by the Legislature in past years. The Administration noted during a prior Subcommittee hearing that they would be reversing course on this.
- **$10.1 million (General Fund) to reflect an increase of 188 judicially committed penal code patients and 128.6 permanent staff to address level-of-care and non-level-of care staffing licensing requirements.** This patient estimate is based on a regression analysis of recent data.
- **$61 million (General Fund) which was shifted from the CA Department of Corrections (CDC) to the DMH budget via a Spring Finance Letter.** This shift which was approved by the Subcommittee in our May 2nd hearing reflects the amount that the CDC already reimburses the DMH for in providing services to certain inmates. (This is just a more effective way to budget the cost.)

- **$733,000 (General Fund) increase to reflect recruitment and retention pay differentials at Coalinga State Hospital and Salinas Valley Psychiatric Program.** This funding is consistent with the plan submitted by the Department of Corrections in response to a recent order in the ongoing Coleman case. (The Coleman case pertains to an ongoing oversight of the provision of mental health services within the Department of Corrections by the courts.)

Summary of Overall Caseload: The DMH May Revision caseload assumes a budget-year population of **5,741 patients for 2005-06** (as of June 30, 2006). Of this total caseload, only 555 patients are committed by County Mental Health Plans. The remaining 5,186 patients are penal-code related patients (698 are SVP patients).

Summary of Changes in Patient Population by Facility

Hospital Summary	January 2005-06 Population	May Revision 2005-06 Population	Difference Population
Atascadero	1,271	1,402	131
Coalinga	583	747	164
Metropolitan	745	745	0
Napa	1,120	1,120	0
Patton	1,376	1,369	-7
Vacaville	295	294	0
Salinas	64	64	0
TOTALS	**5,453**	**5,741**	**288**

Subcommittee Staff Recommendation: The May Revision reflects a significant increase in caseload due to judicially required commitments. It also reflects the technical adjustment due to the Proposition 99 Fund shift, the required recruitment and retention pay differentials at Coalinga State Hospital and related technical adjustments. **No issues have been raised. It is recommended to adopt the May Revision estimate package.**

2. Office of Patient Rights—Need for Assistance

Issue: The Subcommittee is in receipt of a request **to restore $120,000 (General Fund)** to the Office of Patient Rights within the DMH for the contract services that provide patient's rights advocacy services. The DMH has reduced this contract by 15 percent, or $120,000 (General Fund) as part of their unallocated reduction process.

Constituency concerns have been raised regarding this issue because of the ever increasing caseload at the State Hospitals, as noted above, and the complexity of the patient population (about 90 percent penal code, many with violent behaviors).

Under state and federal law, State Hospitals are required to have a compliant process which allows patients to file complaints that their rights have been violated, including conditions of their care. State law requires that the Patient Right's Contractor take action within two days to investigate each complaint.

The lack of having an adequate number of advocates at each State Hospital make it difficult to comply with these requirements and pose a risk that residents could challenge the DMH's failure to provide advocacy services which are compliant with state and federal law.

The Patient Right's Contractor assists in the licensing reviews and advises the DMH on the plans of corrections required by the Department of Health Services (DHS). The DHS has the authority to impose financial fines for patients' rights violations. Therefore, it is in the best interest of the DMH to want to have a fully operational Patient Right's contract.

The state is at risk here. The federal Department of Justice (DOJ) conducted two extensive reviews of Metropolitan State Hospital which have resulted in the state DMH having to make sweeping changes at Metropolitan regarding every aspect of the hospital operations, including significant changes in patient treatment. The federal DOJ is also slated for conducting a review of every one of California's State Hospitals over the next few years. Several of the issues identified in the DOJ report had previously been raised by the independent Patient's Rights contractor. Proactive involvement by the contractor, as well as responding to specific patient complaints, assists the DMH in developing policies and procedures which address deficiencies identified in the DOJ reports.

Subcommittee Staff Recommendation: It is recommended to increase by $120,000 (General Fund) to restore the DMH reduction to the Patient's Rights Contractor.

Questions:

1. DMH, Please provide a brief summary of the functions of the Patient's Rights Contractor. Are these services effective?
2. DMH, How does your funding level on this, with a patient population of 5,741 patients, compare with the DDS' and their Developmental Center population of 3,071 consumers?

3. Sexually Violent Predator (SVP) Evaluation and Court Testimony Estimate

Issue: The May Revision proposes a *net* reduction of $102,000 (General Fund) to the SVP evaluation and court testimony appropriation. The adjustments are shown in the table below.

This evaluation and court testimony estimate relates only to SVP evaluations performed by private contractors for initial, update, replacement and recommitment evaluations, as well as costs for evaluator court testimony.

The table below summarizes the proposed budget and component parts

SVP Program Evaluation & Court Estimate	2005-06 January	**2005-06 May Revise**	**Difference**
Initial Evaluations	**$1,264,000**	**$2,411,000**	**$1,147,000**
Initial Court Testimony	911,000	516,000	-395,000
Initial Evaluation Updates	394,000	487,000	93,000
Recommitment Evaluations	1,369,000	538,000	-831,000
Recommitment Testimony	436,000	243,000	-193,000
Recommitment Updates	319,000	400,000	81,000
Airfare Costs	141,000	138,000	-3,000
Consultation Costs	47,000	46,000	-1,000
Totals	**$4,881,000**	**$4,779,000**	**-$102,000**

The DMH states that this revised estimate is based on their historical data.

Legislative Analyst's Office Recommendation: The LAO contends that the May Revision has over budgeted for the "initial evaluations" component of this proposal by about $811,000 (General Fund). **As such, the LAO recommends an overall reduction of $913,000 (General Fund).** (This consists of the DMH reduction of $102,000 and the additional $811,000.)

The DMH projects that a larger amount of funding is needed for these evaluations based on trending of recent caseload data. However, the LAO thinks that due to some technical adjustments assumed by the DMH, the DMH estimate is in fact, too high.

Subcommittee Staff Recommendation: It is recommended to adopt the LAO recommendation **to reduce by a total of $913,000 (General Fund) to reflect less anticipated need and cost.**

4. Implementation of Medicare Part D—State Hospitals and DMH Staff

Issue: The May Revision is proposing three adjustments within the DMH area related to the implementation of the Medicare Part D Drug Program. Based on these adjustments, a net savings of about $500,000 would be obtained by the state. The proposed adjustments are as follows:

- **$69,000 (General Fund)** to fund an Associate Governmental Program Analyst (two-year limited-term) at DMH headquarters.
- **$806,000 ($500,000 General Fund**--$240,000 one-time only) and $306,000 County Realignment Funds) to support a total of nine positions (two-year limited-term) in the State Hospitals and to purchase computer hardware and software. These positions pertain to Accounting, Pharmacy, Health Records, and technical, analytical staff. Of this total amount, $25,000 is to purchase computer workstations and software, and $194,000 is for one-time only consultant services.
- Increased **revenue of $1.1 million (General Fund)** to the state due to generating additional Medicare revenue from the Pharmacy Drug Plans (PDPs) in the budget year.

Background on the State Hospitals and the Part D Program: The DMH estimates that 850 patients in the State Hospital are Medicare eligible but only 768 will choose to enroll in Part D. Of these, only 26 patients are currently dual eligible (Medi-Cal/Medicare). Those State Hospital patients eligible for Medicare, but who are not dual eligible or low-income, will pay premiums, deductibles and co-payments from their trust accounts or the State Hospital will pay these charges.

Once enrolled, the Pharmacy Drug Plan (PDP) will pay for the cost of drugs for the patient. If a particular drug is not on the PDP formulary, the State Hospital will have to pay for the non-formulary drug. It is estimated that 70 percent of the drugs used by State Hospital patients will be on the PDP formulary.

Each State Hospital will likely become a long-term care pharmacy under each PDP. Every PDP must offer to contract with a long-term care pharmacy willing to accept the PDP's terms and reimbursement rates. If a long-term care pharmacy does not contract with the PDP because its rates are too low, the patient would have to go to a local pharmacy under contract with the PDP. This is not a viable option for patients in the State Hospitals. **The State Hospitals would order drugs from their normal sources and account for drugs given to PDP enrollees.**

The number of PDPs in California will not be known until this fall. Depending on the region, there could be as many as 35 PDPs in California (based on a teleconference call with the federal CMS in March 2005).

Subcommittee Staff Recommendation: It is **recommended to adopt the May Revision as proposed.** There will be considerable work that will need to be done at the State Hospitals to address this complex, new federal program. No issues have been raised.

Questions:

1. DMH, Please provide an overview of how the Part D Program will operate in the State Hospital setting.
2. DMH, Please briefly explain your May Revision request.

5. Department's Proposed Trailer Language for SVP Treatment Restructuring *(See Hand Out)*

Issue: In his January budget, the Governor proposed total savings of $15.2 million General Fund from a series of changes that pertain to the commitment and treatment of Sexually Violent Predators (SVPs). As noted above, one of these proposals was rescinded (i.e., "pre-commitment"). Policy legislation is moving separately from the budget on issues related to extending SVP commitment periods (no budget year savings).

The only remaining issue related to budget year savings is a proposal to restructure the SVP Treatment Program. In the March 7th hearing, the Subcommittee discussed this issue, which proposes savings of $6 million (General Fund) in the budget year. However at that time, the Administration did not have their trailer bill language available so the issue was held "open".

Five months after the release of the January budget, the DMH has now provided proposed trailer bill language with the May Revision. The core components of this language are as follows:

- Effective January 1, 2006, the DMH would restructure the supervision and treatment services provided to SVP patients, including the establishment of a new secure SVP residential licensing category. The treatment would be less than that provided by a licensed health facility. Generally, the concept behind this restructuring is to use less nursing staff and clinical staff.
- Provides the DMH with complete authority in how they would choose to restructure the program.
- Provides the DMH with the authority to not following any other provision of law except those requirements related to fire and life safety.
- Provides that the DMH can place existing health facility beds at Coalinga State Hospital (to be operational as of September 1, 2005) is "suspense" for a period of up to six years.

Background—SVP Treatment Program: The existing Sex Offender Commitment Program designed for SPV patients is organized into five phases. The first four phases are inpatient treatment and the fifth phase is outpatient.

SVP patients entering the SVP Treatment Program enter as Phase 1 patients. Based on their willingness to participate in the treatment programs and their performance, patients "graduate" to the next phase until reaching outpatient status. As of January 2005, there are a total of 135 patients from 32 counties in phases 2,3,4 and 5 of treatment. The balance of the SVP population (424 patients or 76 percent) remain in Phase I as noted below.

Phase 1: Treatment Readiness (474 patients)
Phase 2: Skills Acquisition (107 patients)

Phase 3: Skills Application (19 patients)
Phase 4: Skills Transition (7 patients)
Phase 5: Community Outpatient Treatment (2 patients)

The statute provides that the SVP patient or the DMH Director may petition the court for conditional release (Phase 5) after the initial two-year commitment. Unlike the initial commitment or re-commitment process (jury trial), the process for a petition for conditional release requires only a court hearing before a judge, no jury trial.

Background—Designation of SVP: In 1995, the Legislature established a civil commitment process for offenders deemed by a court or jury to be a Sexually Violent Predator (SVP). The SPV law is designed to ensure that specified offenders receive intensive inpatient treatment, as well as outpatient treatment and supervision upon their release from state prison. To qualify as an SVP, an offender must have committed specified sexual acts (e.g., rape, sodomy and lewd or lascivious acts with a child) involving two or more victims and have a diagnosed mental disorder that makes the individual likely to engage in sexually violent predatory behavior in the future.

Background---Overview of the Process: All SVPs first serve their sentence in a CDC prison. Through an initial records review process, the CDC and Board of Prison Terms refer records of inmates suspected of meeting SVP criteria. The DMH orders evaluations to determine whether the offender potentially qualifies for a SVP commitment.

Any inmate meeting SVP criteria then receives a clinical evaluation to determine if a diagnosed mental disorder exists. Inmates meeting all the statutory SVP criteria are referred to District Attorneys for their action. For those cases which a DA decides to file a petition, a probable cause hearing is held before a judge to determine if the facts of the case warrant a full commitment trial. If a jury or judge finds that it is likely an individual would re-offend, then the individual is committed to the DMH State Hospital system for treatment and supervision. The statutory length of commitment is presently two years.

Subcommittee Staff Recommendation: It is **recommended to reject the proposed trailer bill language and to restore the $6 million (General Fund) that was identified as a savings.**

Subcommittee staff has been advised by the Senate Public Safety Committee that the proposed language would likely be declared unconstitutional. Defendants have successfully challenged how SVP programs are implemented, despite adequate provisions in statute requiring treatment.

Department of Finance

1. Department of Finance--Trailer Bill Language regarding Health & Human Services

Issue: The Subcommittee is in receipt of proposed trailer bill language received from the Department of Finance on May 19th.

The proposed language from the DOF is as follows:

Section 27 is added to the Welfare and Institutions Code to read:

27. (a). The Department of Health Services, Department of Alcohol and Drug Programs, Managed Risk Medical Insurance Board, Department of Developmental Services, Department of Mental Health, Department of Rehabilitation, and Department of Child Support Services shall annually submit by September 10 of each year and March 1 of the following year, to the Department of Finance for its approval, all assumptions underlying all estimates used to develop the departments' budgets.

(b) The Department of Finance shall approve, modify, or deny the assumptions underlying all estimates within 15 working days of their submission. If the Department of Finance does not modify, deny, or otherwise indicate that the assumptions are open for consideration pending further information submitted by the department by such date, the assumptions as presented by the submitting department shall be deemed to be accepted by the Department of Finance as of that date.

(c) Each department shall submit an estimate of expenditures for each of the categorical aid programs to the Department of Finance by November 1 of each year and April 20 of the following year. Each estimate shall contain a concise statement identifying applicable estimate components, such as caseload, unit cost, implementation date, whether it is a new or continuing premise, and other assumptions necessary to support the estimate. The submittal shall include a projection of the fiscal impact of each of the approved assumptions related to a regulatory, statutory, or policy change; a detailed explanation of any changes to the base estimate projections from the previous estimate; and a projection of the fiscal impact of such change to the base estimate.

(d) These departmental estimates, assumptions, and other supporting data as have been prepared shall be forwarded annually to the legislative fiscal committees not later than January 10 and May 15 if this information has not been released earlier by the Department of Finance. Each estimate shall identify those premises to which either of the following applies:
(1) Have been discontinued since the previous estimate was submitted.
(2) Have been placed in the basic cost line of the estimate package.

Subcommittee Staff Recommendation: It is recommended **to reject this language without prejudice to send it to Conference for several reasons.**

First, there is existing statute regarding the preparation of estimate packages and assumptions. Section 14100.5 of Welfare and Institutions Code addresses the Medi-Cal Program assumptions and estimates. Section 10614 of Welfare and Institutions Code addresses the Department of Social Services estimate package. Therefore, it is not clear how the DOF language affects this existing statute.

Second, the language has just been received and needs to be analyzed. There may be aspects of the language that the Legislature would like to change to address concerns with receiving more comprehensive descriptions of budgetary assumptions and estimates.

Questions:
1. DOF, Please present the proposed trailer bill language.
2. LAO, What are your initial thoughts? Do you have any initial suggestions?